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San Francisco HIV Prevention Plan

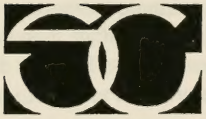
A Product of the

HIV Prevention Planning Council

A Community Planning Body Funded by
the Centers for Disease Control and Prevention

Cooperative Agreement No. U62/CCU902017

Prepared By



Support Center for Nonprofit Management
San Francisco, CA

and

San Francisco Department of Public Health
AIDS Office

December 1994

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HIV PREVENTION PLANNING COUNCIL

City and County of San Francisco — Department of Public Health

December, 1994

Dear Reader:

This document is the first comprehensive Community HIV Prevention Plan for the City and County of San Francisco. It is the product of the concerted efforts of individuals who reflect those affected and infected by HIV, prevention providers, government agencies, researchers, and advocates. Without the commitment of time, energy, and personal and professional expertise of the members of the HIV Prevention Planning Council, consultants, AIDS Office staff, and other community participants, this plan would not have been possible.

We recognize that everyone in San Francisco has a vital stake and role in the development of a viable, efficient community-based HIV prevention program. Regardless of race, age, gender, or sexual orientation, HIV and AIDS impact upon all aspects of our city and our communities. The need for an effective prevention program is of particular importance in San Francisco, where the high presence of HIV makes the opportunity for transmission and infection a continuing and critical issue.

The importance of health and academic institutions and community organizations in contributing to the development of an effective planning process is well supported by both research and practice. In order to be effective, programs and policies for HIV prevention must be responsive to the daily realities of peoples' lives. Culturally competent planning, which is the foundation of the San Francisco approach, must take into account such frequently encountered issues as substance use, sexual experimentation, mental health and self-esteem, and poverty. Until now, broad-based community participation has not been invited or acknowledged in local planning efforts.

This plan will continue to be responsive to the changing dynamics and realities of the HIV epidemic in San Francisco. With ongoing community participation in the planning process, HIV prevention will no longer be "business as usual." As a result of a thorough examination of existing data, including identification of unmet needs and recognition of the significance of culturally competent planning, we have shifted from the traditional identification of high risk populations to a focus on the behaviors that place people at risk for HIV transmission.

This is a beginning. The process that we have begun must continue and expand in order to effectively meet the challenges that lie ahead.

Sincerely,

Cynthia Gomez — Valerie Kegebein — Kerrington Osborne

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GUIDE TO THE PLAN

This HIV Prevention Plan presents the findings of a six-month study commissioned by the Centers for Disease Control and Prevention (CDC) as part of a new, community-based approach to HIV prevention planning. The CDC mandated the formation and procedures of the plan's primary author, the newly-convened HIV Prevention Planning Council, as well as the scope of the plan, its organization and presentation of data.

The plan is organized as follows:

- **Executive Summary** presents a brief summary of the report.
- **Executive Summary for Public Hearings** distills the overarching themes found in Chapter 5: Summary and Needs Assessment.

Following this summary, the first five chapters survey the current state of the HIV epidemic in San Francisco, and examine the city's HIV prevention needs.

- **Chapter 1: Epidemiologic Profile**
- **Chapter 2: Resource Inventory (of HIV Prevention Services)**
- **Chapter 3: Strategies and Interventions**
- **Chapter 4: Priority Setting Criteria**
- **Chapter 5: Summary and Needs Assessment**

The next three chapters establish planning objectives and areas for system-wide coordination among agencies contributing to the HIV prevention effort. This section also assesses the technical assistance needs of community-based organizations (CBOs), as the first step in developing these organizations' capacity to better serve their community. This section includes the following chapters:

- **Chapter 6: Priority Goals and Objectives**
- **Chapter 7: System Linkages and Coordination**
- **Chapter 8: Technical Assistance (for CBOs)**

Finally, the last chapter discusses the community-based planning process, and examines how successfully this process achieved its goals. This information is presented in:

- **Chapter 9: Evaluation**

Please note that each chapter builds upon the others. As such, it is critical that no single chapter be read independently, or be perceived as holding greater or lesser weight than the other chapters.

Appendices and bibliographies appear throughout the report, located within each chapter for convenience.

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ACKNOWLEDGMENTS

Special thanks and appreciation go to the many people (and their sponsoring organizations) who contributed countless hours to the production of this document. These include: current and former members of the HIV Prevention Planning Council (HPPC) and its committees; the Co-Chairs of the HPPC; the Support Center for Nonprofit Management; and the San Francisco Department of Public Health AIDS Office.

We also wish to acknowledge the contributions of those members of the public who participated in community meetings, focus groups, and public hearings, through which they provided invaluable advice and input to the HIV prevention planning process.

Executive Summary

EXECUTIVE SUMMARY

A. Introduction

This HIV Prevention Plan, the first of its kind in San Francisco, is a significant product of a community planning process which began in early 1994. The AIDS Office of the San Francisco Department of Public Health, responding to a Request for Proposal issued in late 1993 by the Centers for Disease Control and Prevention (CDC), applied for moneys to be specifically dedicated to the initiation of a community-wide process leading to the development of an HIV Prevention Plan for San Francisco. With approval of that proposal and operating under guidelines issued by the CDC, the AIDS Office created a new community planning body. In an effort to make that body representative of San Francisco's diverse communities, nominations were sought from prevention providers, researchers/educators, and the general community. From the 93 nominations received by the deadline, a screening committee (composed of the chairs/co-chairs of the AIDS Prevention Advisory Committee, Ryan White CARE Council, and the People of Color Advisory Committee) forwarded 37 names of individuals representing as many aspects of the city's population as possible to the Directors of the Department of Public Health and the AIDS Office for consideration and possible appointment. All 37 persons were appointed and officially became members of a new HIV Prevention Planning Council (HPPC).

The membership of the HPPC was designed to closely reflect the characteristics of the HIV epidemic (both current and projected) in San Francisco. It is ethnically diverse (with 7 African American members; 7 Latino members; 5 Asian/Pacific Islander members; 2 Native American members and 13 White members as of 8/31/94) and represents the sexual orientation diversity of the City (12 gay/bisexual men; 4 lesbians; and 1 transgender woman are members of the council). People with HIV/AIDS are also among the members.

In its first few months of operation, the HPPC was faced with the formidable task of developing (by the end of September, 1994) an HIV Prevention Plan which addressed: the epidemiology of HIV/AIDS in San Francisco; prevention resources currently available in the community; prevention strategies and interventions; prevention goals, objectives and linkages; an assessment of needs for defined populations; proposed criteria for establishing priorities; technical assistance needs of prevention providers (and the AIDS Office); and evaluation. To enhance this process, consultants from the

Support Center for Nonprofit Management were retained under a sole-source contract with the AIDS Office.

Three co-chairs (one designated by the AIDS Office and two selected by the HPPC (from the community) to facilitate the plan development process. The co-chairs, recognizing the need to move speedily, decided to create sub-committees which would be responsible for development of the individual elements of the plan. The sub-committees (Epidemiology and Needs Assessment; Strategies and Interventions; Goals and Objectives; Criteria for Priority Setting; and Technical Assistance) had their membership expanded (beyond the HPPC membership itself) to include interested members of the community at large. Sub-committee meetings were held at least twice a month; HPPC meetings were held twice a month during the plan development period.

As each chapter was developed, public input was solicited through public meetings, focus groups and meetings of the various bodies that serve in an advisory capacity to the AIDS Office. The input from these efforts was provided to the sub-committees where decisions were made about inclusion of the information before the draft chapter was presented to the full council by the chair of the appropriate sub-committee with back-up and support from other members of the sub-committee. Each chapter was voted on and either approved or sent back to the sub-committee for revision. The result of this feverish activity by HPPC members, community members who served on HPPC sub-committees and members of the public who participated in focus groups and community meetings is this comprehensive HIV Prevention Plan for San Francisco.

B. What is the HIV Prevention Plan?

The HIV Prevention Plan is largely about helping HIV prevention providers get better organized (i.e. finding out what we know, what we don't know, what is working and what is not working) through meaningful planning for and evaluation of the prevention system in San Francisco. It is an effort designed to implement strategies and interventions which will ultimately stop the spread of HIV in the City. It defines unmet prevention needs as well as the existing "known" needs, emerging trends, the data we now have and don't have, as well as the data that is needed. This plan represents a shift in the basic assumptions underlying HIV prevention planning. Formerly, prevention efforts were directed to defined "high-risk" population groups without regard to what actually put those populations at risk. This plan addresses the HIV prevention needs of various populations on the basis of

their high-risk sexual and drug using behaviors. It recognizes that behavior is what puts people at risk -- not the fact that they belong to a particular ethnic, cultural, or other group.

C. What Does the HIV Prevention Plan Include?

The HIV Prevention Plan consists of nine (9) chapters covering: the epidemiologic profile of HIV/AIDS in San Francisco; an inventory of prevention resources; HIV prevention strategies and interventions for target populations; the criteria used in setting priorities; a comprehensive summary and needs assessment; priority goals and objectives; system linkages and coordination; technical assistance for community based organizations and other HIV prevention providers; and an evaluation of the process by which the plan was developed. Following is a brief synopsis of each chapter:

CHAPTER 1: EPIDEMIOLOGIC PROFILE

This profile reflects the current and future HIV/AIDS epidemic in San Francisco. As the cornerstone of the Plan, it is probably the most comprehensive analysis of HIV/AIDS among San Francisco's multiple transmission groups. These groups, as identified by the HIV Prevention Planning Council (HPPC), emphasize the need to organize epidemiological data and characterize the risk of infection based on behavior rather than the traditional "risk" groups that have been used in the past. When information regarding the transmission groups is compared with behavior and transmission activity (e.g. blood-to-blood, semen to blood, vaginal secretions to blood) some clearly defined high risk target populations do emerge.

The transmission groups approved by the HPPC for the Epidemiologic Profile are:

- women who have sex with women
- women who have sex with women and inject drugs
- women who have sex with men and women
- women who have sex with men and women and inject drugs
- women who have sex with men
- women who have sex with men and inject drugs
- men who have sex with women
- men who have sex with women and inject drugs
- men who have sex with men and women
- men who have sex with men and women and inject drugs
- men who have sex with men
- men who have sex with men and inject drugs

The high risk target populations (discussed in detail in Chapter 5) which emerge from a review of the sociodemographic, behavioral, and epidemiologic indicators of HIV risk are:

- Injection drug users
- Gay Men
- Youth
- Women
- Transgendered Male-to-Females
- Homeless Adults
- Immigrants
- Incarcerated Adults

In addition, the Epidemiologic Profile presents information/data from HIV Counseling and Testing, a comprehensive list of published Behavioral Studies and Surrogate Markers. Readers may find the Epidemiologic Profile in Chapter 1 of the Plan.

CHAPTER 2: RESOURCE INVENTORY

The CDC Guidance mandates the creation of an inventory of resources currently in use in San Francisco, and an analysis of the effectiveness of the strategies and interventions these resources support. Because no standardized format is available from which to develop a comprehensive inventory of all HIV prevention resources (including those agencies which do not receive CDC or State of California funds) in San Francisco, the picture remains incomplete. Chapter 2 of the plan summarizes what prevention providers have reported about what prevention programs and activities they provide, what population groups they have targeted, and who they actually served in the previous year. Ideally, such an inventory would identify gaps in services but, because of reporting problems, resource gaps remain unidentified.

CHAPTER 3: STRATEGIES AND INTERVENTIONS

This chapter offers findings about current and future strategies and interventions, and about the ideas and opinions of members of target populations, prevention providers and funders. This chapter also identifies a number of *overarching themes* which have considerable relevance in any discussion of HIV prevention strategies and interventions. These include:

- HIV prevention strategies targeting IDU activity must also address sexual behavior modification;
- HIV prevention strategies must address non-IDU substance use issues as well as IDU activity;
- HIV prevention messages must reach beyond behavior modification to address sociological and psychological issues such as self-esteem and the importance of community membership;
- Information on prevention services and programs must be gathered in a manner which enables measurement of unmet needs;

- Services must be targeted at who is at highest risk and perceptions of service decisions must be need-based;

- Information and education about HIV transmission must be delivered in a clear, concise, consistent, and culturally appropriate manner.

This chapter also includes a brief discussion and assessment of each of the major HIV prevention strategies currently in use in San Francisco. These include:

- HIV counseling, testing, referral and partner notification (CTRPN);
- Individual level interventions
- Group level interventions
- Community level interventions
- Public Information programs

CHAPTER 4: PRIORITY SETTING CRITERIA

This chapter identifies criteria for selecting priorities in four areas: target groups, strategies, resource allocation and research. In each instance, the criteria are preceded by guiding principle(s) for using the criteria. These principles are:

a. **Target Groups:** There is only one factor for determining which populations need focused prevention efforts; namely a significant risk of contracting HIV. Risk of contracting HIV is caused by practicing certain, identifiable behaviors.

b. **Selection of Strategies:** Strategies will be consistent with the values, norms, and consumer preferences of the intended target population.

c. **Resource Allocation:** To prevent as many infections as possible with limited resources, intensive prevention efforts should be targeted to groups and individuals at higher risk. Basic, non-targeted prevention information and activities must be available at some level to every individual or group no matter how small the risk. Other resources need to be mobilized to assure that all needs are identified and addressed.

d. **Research Priorities:** The guiding principle is to find out what we most need to know about populations at high risk and populations which may be a high risk but about which there is little data.

CHAPTER 5: SUMMARY AND NEEDS ASSESSMENT

This chapter presents an extensive discussion of those communities/target populations at highest risk for HIV transmission in San Francisco. It includes an introduction to the population, unmet needs that have been identified and recommendations for prevention. The specific population groups (which emerged from the data in the Epidemiologic Profile) are:

- Injection drug users
- Gay Men
- Youth
- Women
- Transgendered Male-to-Females
- Homeless Adults
- Immigrants
- Incarcerated Adults

The principal conclusion in this chapter is that issues of self esteem, mental health, poverty, homophobia, racism, and sexism are issues which have plagued communities long before the onslaught of AIDS. What makes AIDS prevention planning so difficult is that the causes of risky behavior are so inextricably linked with these larger social issues. Therefore, in order to effectively address behavior change to stop risky behavior(s) among the groups listed above, these larger issues also must be directly addressed. It is recognized that the recommendations included in this chapter will require great time and effort to accomplish. What is particularly important is that these recommendations are viewed from the proper perspective. None of us expects that issues such as self esteem and homophobia will be solved in one year or ten years. What we do expect is that small, measurable steps towards solving these problems can be developed, implemented, and evaluated by HIV prevention planners in a realistic and timely fashion.

The final recommendation of this chapter, and perhaps its most crucial one, is that the HIV prevention planning process and all those who have participated in it, is recognized and accepted as the first small step in a very long process. This process, which has raised more questions than it has

answered, requires a commitment towards working for the answers to those questions and an acceptance of prevention planning as part of the permanent HIV prevention process.

CHAPTER 6: GOALS AND OBJECTIVES

The HIV Prevention Planning Council, in adopting the planning goals and objectives, and the AIDS Office, in incorporating them into its operational programs, have accepted the fact that HIV prevention can only be successful if it focuses on the behaviors that place people at risk for HIV transmission. This chapter of the HIV Prevention Plan places emphasis on the standardization of essential aspects of HIV prevention so that meaningful planning and evaluation can take place at the system level.

Five goals (with supporting objectives) have been put forward. These are:

- Reduce new HIV infections in the City and County of San Francisco to as close to zero as possible by the year 2000. To do this, we will target both HIV-positive and HIV-negative communities.
- Standardize units of service definitions for HIV prevention services by the end of 1995, so that the work of different providers can be looked at in the context of the overall prevention effort in the City.
- Make evaluation possible: establish a standard evaluation system for prevention efforts.
- All HIV prevention providers in San Francisco will have the technical and administrative capabilities to provide competent and appropriate prevention programs.
- Prevention efforts shall be culturally appropriate.

CHAPTER 7: SYSTEM LINKAGES AND COORDINATION

This chapter identifies the coordination and linkages between the AIDS Office, local government, HIV prevention providers, the private sector, and the broader community necessary to facilitate the accomplishment of the Goals and Objectives outlined in the Plan. Toward this end, the goal of cultural competence and the specific objective regarding the coordination of

primary and secondary prevention efforts guide all of the activities outlined in this section of the Plan.

CHAPTER 8: TECHNICAL ASSISTANCE

This section of the Plan addresses the technical assistance needs of prevention community based organizations, other service providers, and the AIDS Office. It focuses on the provision of training or expertise that will help agencies to plan, implement, and evaluate their HIV prevention efforts more effectively.

CHAPTER 9: EVALUATION

This chapter recognizes the fact that evaluation is both useful and necessary. It indicates that evaluation is a quality assurance method for determining the effectiveness of (in this instance) the planning process and serves as a monitoring tool to measure success, to inform decision-making, and to direct necessary changes in the process.

The evaluation is designed to:

- Document that the community planning process actually took place.
- Determine whether or not the short-term program goals of the planning process were met.
- Identify strengths and weaknesses of the planning process.

As part of the process, the plan details three phases of evaluation:

Phase I: evaluation of the community planning process which led to the development of this plan.

Phase II. evaluation of the contractual services of the subcontractor/consultant.

Phase III. evaluation of the implementation of the recommendations and priorities described throughout the plan.

Executive Summary

Appendix A:

Executive Summary for
Public Hearings

EXECUTIVE SUMMARY FOR PUBLIC HEARINGS

Introduction

Everyone in San Francisco has a vital stake and a role in the development of a viable, efficient community-based HIV prevention program. Regardless of race, age, gender, or sexual orientation, HIV and AIDS impact upon all aspects of our city and our communities. The need for an effective prevention program is of particular importance in San Francisco, where the high presence of the virus makes the opportunity for transmission and infection a critical, continuing timely issue.

The importance of health and academic institutions and community organizations in contributing to the development of an effective planning process is well supported by both research and practice. In order to be effective, programs and policies for HIV prevention must be responsive to the daily realities of peoples' lives. Culturally competent planning must take into account such frequently encountered issues as substance use, sexual experimentation, mental health and self-esteem, and poverty. Yet, until now, broad-based community participation has not been invited or fully acknowledged in community planning efforts.

In late 1993, the Centers for Disease Control and Prevention awarded 65 grants across the country for the specific purpose of creating community-wide planning processes for HIV prevention. Within California, the cities of Los Angeles and San Francisco, as well as the State of California, were recipients of CDC funding.

The 37-member HIV Prevention Planning Council (HPPC), was formed early in 1994. Specifically chosen to reflect the characteristics and diversity of the HIV affected communities in San Francisco, the HPPC is responsible for the overall task of developing the city-wide prevention plan. Under CDC guidelines, the plan must address the following specific issues: the epidemiology of HIV/AIDS in San Francisco; current strategies and interventions used to fight the spread of the epidemic; a model for establishing priority criteria and target populations with the affected communities; and the technical assistance needs of grantees and prevention providers.

In order to be effective, community planning is a continually evolving process. Planning must result in HIV prevention programs which address the prevention

needs of the community. The planning process must be responsive to the changing dynamics of pre-existing needs being met and new HIV needs being identified.

In anticipation of this "cycle of needs," the HPPC viewed its charge in 1994 to be that of building the foundation upon which future planning can be based. Towards that goal, much of this year's plan asks the question, "What is the information that we need to know in order to create and implement effective HIV prevention programs in San Francisco?" The gathering and analysis of this information will continue through 1995 and beyond, because the CDC and the HPPC members believe that better information will lead to better and more effective programs.

Some vitally important information has already been gathered this year. For the first time, this 1995 plan presents a comprehensive epidemiologic profile of HIV and AIDS infection within the city. In addition, the plan incorporates an assessment of what information is and is not available within the city regarding prevention services and planning. Because each chapter of the plan builds upon the next, it is critical that no one chapter be read independently of the others. One of the recommendations which recurs throughout the plan is that of suggesting important research and information-gathering needs which will lead to more informed, thoughtful planning in the future.

It is therefore important that the 1995 plan be seen as a beginning rather than an ending. This year's plan is largely about getting the system organized (i.e. finding out what we know and don't know, what is and is not working, etc.) so that we can do meaningful evaluations, and subsequently, meaningful planning, to stop the spread of HIV in San Francisco. The publication of this plan is therefore merely the first, crucial step in a process which has as its goals both short-term recommendations, and long-term strategic planning implications.

Both goals are equally important. The personal suffering and shortened lives which individuals with HIV and AIDS must endure is, for many seemingly unaffected by the disease, beyond understanding. And yet all of us, infected or not, pay heavily for the losses which HIV transmission exacts from our communities. We pay in diminished economic productivity of an entire generation, and the potential to lose that productivity from future generations. We pay immense social costs by somehow having to find the means to grapple with our own personal grief and loss as we watch friends, lovers, co-workers, and family become infected or succumb to AIDS. And we pay the moral costs of knowing that every time another of us becomes infected, there is someone who asks, "What could I have done to prevent this from happening?"

These outcomes can be reversed. But to do so, we must all make a concerted effort to create communities that actively seek to develop commonalities from our differences, to recognize that our battles must be waged against the disease and not each other, and to support education, promote health, and provide every opportunity we can to stop even one more person from becoming infected.

Overarching Themes

Throughout the course of developing this plan, several overarching themes emerged. These are the themes which arose in one section of the plan (for example, in the development of the Epidemiologic Profile), and then resurfaced repeatedly in other areas of the plan (i.e. the Goals and Objectives, or the Resource Inventory). As such, these themes form the basis from which needs and recommendations for action arise.

☛ Behavior is the Primary Emphasis When Assessing Degree of Risk for HIV Transmission and Infection.

The Council decided to make a serious shift in the way HIV risk has traditionally been assessed. Instead of looking at risk by sociodemographic status (e.g. race/ethnicity), as has been commonly done in the past, the council chose to prioritize risk by the most efficient to the least efficient modes of HIV transmission (e.g. blood to blood, semen to blood, or vaginal secretion to blood transmission) and the behaviors that lead to transmission (e.g., sharing needles without cleaning them, unprotected anal intercourse). By so doing, the council is focusing first upon overarching themes of transmission which affect all groups, and then looking at how particular behavioral risks are increased by actions which are particular or more pronounced within target populations.

☛ Target Groups are Identified in Order to Assess Who is at Risk, but NOT to Prioritize Relative Risk Between These Groups.

The plan does examine which groups in general are at higher risk. What the plan does not do is try to prioritize relative risk between target groups. Therefore, the plan does say that injection drug users are at higher risk than non-IDU men who have sex with women, but it does not say if IDUs are at higher risk than gay men, nor does it try to make comparisons between specific groups.

- **HIV Prevention Strategies Targeting Injection Drug Use Must Also Address Sexual Behavior.**

For every target population, regardless of race, ethnicity, gender, or age, the highest risk of HIV infection occurs among injection drug users (IDU) who have sex with men. In addition, IDUs are disproportionately represented among homeless and transient populations. And for every one of these populations, IDUs regularly report that although they often adapt their IDU behavior to incorporate safer drug use, they just as often do not modify sexual behavior to engage in safer activity.

In order to be successful, then, programs targeting IDUs must address HIV infection in the larger context of how the disease affects their daily lives, and not just how a particular manifestation of behavior might be altered by a specific intervention. For instance, the problem of IDUs engaging in high risk sex cannot be solved simply by handing out condoms. While at first glance this may seem to be a logical intervention, it addresses only the fact that IDUs engage in sex, and ignores the greater, more important issues of when and how IDUs engage in risky behavior. It is not realistic to expect people who engage in sex while under the influence of drugs, or those who must trade sex in order to get drugs, to demand condom use under these situations.

- **HIV Prevention Strategies Must Address Non-IDU Substance Use Issues as well as IDU Activity.**

Initial research indicates that non-IDU substance-using populations may be at high risk for HIV infection. Many of the issues linking IDU activity with unsafe sex also apply to non-IDU substance users and unsafe sex. Like strategies designed to target IDUs, programs aimed at other substance users must address not only how users engage in sex, but why and under what circumstances they do so.

In order to do so effectively, there is a need to institutionalize HIV primary prevention programs within substance abuse treatment agencies. Substance use programs which include condom distribution in conjunction with education, street outreach, and referrals for mental health and treatment will more closely meet the needs of substance users. And because substance abuse agencies are a point of entry and way of reaching individuals who may be at high risk for HIV infection, training staff in HIV prevention is critical. Interventions must be designed with the end result of helping users to develop skills for having and maintaining sober sex, since relapse of one type of behavior may mean relapse into another.

- **HIV Prevention Messages Must Reach Beyond Behavior Modification to Address Sociological and Psychological Issues Such as Self-Esteem and the Importance of Community Membership.**

Prevention strategies and interventions often focus exclusively upon altering behavior, and not upon altering the sociological and psychological factors which may influence that behavior. Educational information about the causes and methods of HIV transmission will, in and of themselves, do little to change peoples' behavior. In parts of the gay male community, even though a high level of knowledge about HIV transmission exists and condom use and safe sex practices have increased, a high degree of unsafe sex still occurs.

Researchers and social scientists believe that this barrier between knowledge and action, or between information and implementation, is in part caused by sociological and psychological pressures which discourage safe sexual practices. For instance there already exists a growing perceived cultural division in the gay community between HIV positive and HIV negative gay men. Focus group participants and providers alike report that the emergence of these two subcultures has created a sentiment within parts of each subculture that men are not really part of the gay community unless they are seropositive.

People at risk for HIV infection report other societal influences which inhibit prevention efforts. Many gay men believe that seroconversion is inevitable, and some believe that they will feel a sense of relief and stability once that line is crossed. This stability can be perceived as desirable when compared to the uncertainty and difficulty associated with remaining HIV negative. In order to be effective, then, HIV prevention programs must address a broader range of psycho-social needs within affected communities.

- **Programs Must be Targeted at Who is At Highest Risk, and Perceptions of Service Decisions Must be Need-Based.**

In the past, identification of priority populations and priority interventions was mainly defined by the State and Local health departments based on the best available data. There were often many factors that directly influenced these decisions and unfortunately, those factors often had no relevance to sound public health practice. The situation was compounded by the lack of complete information on various populations, particularly injection drug users, female partners of IDUs, and gay men of color. These and other factors resulted in the delayed identification of some at-risk populations.

Today, prevention planners have the opportunity to learn from the experience of the past. Community planning has changed the very framework in which decisions are made. There is now a partnership between infected individuals, affected communities, prevention providers, researchers, public health officials, and others. There is greater knowledge on populations at risk for HIV infection. By no means is there enough data on all populations, but planning is at a point where planners can begin to focus on the behaviors that place people at risk for HIV infection. Planners can begin to identify research priorities. They can tap the wisdom of all who have been involved in community planning, from the executive director to the outreach worker. It is the culmination of these factors which will eventually lead to HIV prevention priorities being based upon sound public health policies -- where HIV prevention interventions are targeted to those at highest risk and with the greatest need for health education and health promotion.

- **Education about HIV Transmission Must be Delivered in A Clear, Concise, Consistent, and Culturally Appropriate Manner.**

All populations, regardless of risk need appropriately designed prevention education. While some of these needs can be met only through interventions tailored to very specific sub-group requirements, there are some over-arching needs which crossover to all communities. For instance, prevention providers must present uniform, unambiguous, non-contradictory data about safe and unsafe behavior. Prevention service clients report that with regard to certain behaviors (most notably oral sex), they feel overwhelmed by the amount of information which they get, much of what they perceive to be contradictory.

- **Behavior Change Must be Targeted at Both Group and Individual Norms.**

All communities have difficulty in taking responsibility for changing individual behavior, particularly if the wider peer, cultural, and social groups within which the individual mores are not receptive to that behavior change. For instance, it is difficult for gay men to consistently practice safer sex in an environment which often measures acceptance by sexual activity. In order for strategies targeting individual change to be effective, those strategies must be developed in conjunction with larger community-change oriented interventions which have the same message, goals, and means of achieving the desired outcomes.

- **Whenever Possible, Prevention Messages and Education Must be Delivered by Community Peers.**

In HIV prevention, the messenger is as important as the message itself. People inherently place greater trust in messages delivered by people who look like them, act like them, live where they live, and speak their language. Many people also report being powerfully affected by HIV prevention messages delivered by HIV positive peers. The ability to self-identify with a person, to be able to say, "This could be me," is, for many, the strongest prevention message available.

- **HIV Prevention Strategies Must be Based Upon a Health Promotion Model.**

For HIV prevention efforts to make demonstrable reductions in the number of new HIV infections, strategies previously designed using the Disease Prevention Model must be reexamined. Based on clinical outcomes, the Disease Prevention Model has been shown to be inherently flawed when applied to HIV strategies. In its place, the HPPC has chosen to follow a Health Promotion Model. Health Promotion and Health Education Models recognize the value in keeping individuals from becoming infected in the first place. The focus is on health, not sickness. Therefore, by placing emphasis on behaviors, as the HPPC plan does, the psychosocial and sociodemographic barriers to behavior change can be assessed, and interventions can be designed to enable individual and community level changes.

Unmet Needs and Recommendations for Action

- **Information on Prevention Services and Programs Must be Gathered in a Manner Which Enables Measurement of Unmet Needs.**

One of the most difficult issues in assessing unmet needs is that of accurate measurement of needs which are being met. This problem is heightened in a city like San Francisco where, because of the intensity and volume of AIDS-related research being conducted here, there exists a misperception that such information is readily available. A powerful barrier to changing the current information-gathering infrastructure, then, is this deep-rooted assumption that permeates the HIV Prevention Planning community that comprehensive information does exist somewhere, somehow, and that it will turn up later if one looks hard enough. This misperception often makes people believe that

resources are better spent in areas other than data-gathering, particularly if they are convinced that the data already exists.

A great unmet need, then, is the creation of a uniform, mandatory system of data gathering and reporting, which will better enable prevention planners to assess the current system of prevention services in San Francisco. In many instances, the changes which are needed are minimal; in some cases, all it will take will be making some optional reporting requirements mandatory, or adding a section to the quarterly reporting requirements. In other areas, such as non-government funded services, the change will require greater coordination with funders and grantmakers. Either way, the change is necessary not only to provide planners with better decision-making potential, but also to help debunk the myth that planners are currently working with complete information.

- **Current Strategies and Interventions Must be Re-assessed in Terms of Their Broad-based Efficacy.**

Both current and proposed strategies and interventions for HIV prevention must be examined in order to assess their efficacy as elements of a comprehensive planning strategy. Because the HPPC plan for 1995 recommends that prevention be perceived in the larger contexts of psychosocial care and health promotion, strategies and interventions must also meet this requirement. In the past, interventions were often designed with a specific action in mind (e.g. use a condom during anal sex), without taking into account the greater context of how and why behaviors occur (e.g. people are less likely to use condoms when under the influence of alcohol or drugs). In order for strategies and interventions to be successful, <u>all</u> interventions must be re-examined for this contextual component. Those which address broad-based contextual issues should be maintained and expanded. Those which do not take a holistic approach must be modified if possible, and terminated if modification is not an option.

- **Monitor Programs Frequently, and Provide Timely, Comprehensive Technical Assistance Interventions to Service Providers.**

The 1995 HPPC plan calls for service providers to make several changes to the way services are currently delivered. A cornerstone of this recommendation is the need for prevention messages to be delivered in a clear, consistent manner. Another is the desire to involve more HIV-positive people in prevention planning and service delivery. Coordination and training for service providers is a primary need, as is frequent monitoring and assessment of providers as they incorporate change. Part of the 1995 HPPC plan specifically mandates technical

assistance training to providers; the programs developed as part of the plan should be expanded and maintained in future years.

☛ **Develop and Implement Comprehensive Evaluation and Assessment Tools to Measure Prevention Service Provision.**

A primary unmet need within the HIV prevention planning structure in San Francisco is that of uniform, comprehensive data gathering, evaluation, and assessment tools. There are currently no such specific requirements mandated by any governing or funding body, public or private, within the city of San Francisco. While certain bodies, such as the AIDS Office, do require the filing of quarterly reports and other reporting demands, there is little uniformity in how these guidelines are fulfilled. This results in overcounting of some services and undercounting of others.

Moreover, there is little, if any, information available on privately funded prevention programs. For this reason, an accurate assessment of the scope and efficacy of prevention programs in the city is nearly impossible to generate. In order to develop effective policies, a clearer baseline analysis of services must first be generated. Uniform, standardized reporting techniques will make such data-gathering possible.

☛ **Greater Data-Gathering for All Communities Affected by HIV.**

An unmet need which is raised throughout the Epidemiologic Profile and Behavioral Summary is that of more comprehensive data-gathering. The Epidemiologic Profile highlights the fact that for some populations, almost no informational data exists at all. For instance, there is not even an accurate count of the number of transgendered people currently living in San Francisco. For other populations, such as gay men, there is a great deal of information, but categorization is widely splintered (e.g. some studies include bisexual men with gay men, others do not).

Uniform data-gathering in specific areas highlighted by the Epidemiologic Profile will result in better defined, more comprehensive statistical information which will in turn lead to better designed, more comprehensive prevention planning programs.

- **Continuously Assess Unmet and Met Needs.**

As prevention programs are developed, implemented, and reach their goals, the spectrum of met and unmet needs for HIV prevention planning will shift as old needs are met and new needs arise. In order to insure that highest priority is being given to the greatest unmet needs, a structured, uniform method of evaluating met and unmet needs must be developed and implemented through a process which involves community members, researchers, and government policy makers at all levels.

Structure of The Plan

The HPPC Prevention Plan is divided into nine chapters. As mentioned elsewhere in this document, each of these chapters builds upon and should be viewed in conjunction with the others. As such, it is critical that no single chapter be read independently, or be perceived as holding greater or lesser weight than the other chapters. The nine chapters are presented in the following order:

Chapter 1: Epidemiologic Profile and Behavioral Summaries
Chapter 2: Resource Inventory of Current HIV Prevention Services
Chapter 3: Current HIV Prevention Strategies and Interventions
Chapter 4: Priority Setting Criteria
Chapter 5: Needs Assessment
Chapter 6: Goals and Objectives
Chapter 7: System Linkages and Coordination
Chapter 8: Technical Assistance
Chapter 9: Evaluation

Conclusion: Transforming Risk Into Opportunity

An effective community planning process for HIV prevention will be in the forefront of action to bring challenging and coherent programs to today's communities at risk for HIV infection. But they cannot do the job alone. The work of developing programs and policies that respond to the needs of communities at risk must be embraced by all concerned groups and citizens.

The dedication and commitment of each of these sectors is needed to achieve a new understanding of and appreciation for the complexity of an issue such as HIV prevention. But understanding and appreciation by themselves are not enough; they must lead to action. We can tackle the vast problem of reforming and restructuring how we wage our battle against HIV as long as we set our minds to the task. At the end of the nineteenth century, changing social norms and a public outcry against stagnant and ineffective societal tools of change resulted in the Progressive Era, and sweeping social change that resonated throughout every aspect of American life: law, government, education, and social welfare.

Although different in nature and scope, we are at another crossroads when sweeping change is demanded. Fifteen years into the AIDS epidemic, no cure is in sight, while new infections continue to occur. It is time that we rethink and redesign the weapons with which we will wage the battle for prevention. And it is from the communities at risk and the community planning process that the development of these new tools will occur. Following this new tactic will involve risk, but it is only through taking risks that we will create these new, vital opportunities for change.

Chapter 1:

Epidemiologic Profile

CHAPTER 1: EPIDEMIOLOGIC PROFILE

Introduction

The acquired immune deficiency syndrome (AIDS) epidemic in the United States continues to evade the best efforts of scientists to find either an effective vaccine or a cure. Since its identification in the early 1980s, behavioral change strategies have come to represent the best hope of halting the further spread of HIV. In the event a vaccine or cure is discovered, targeted prevention programs will continue to play a significant role in efforts to prevent new infections.

The challenge before us is to identify who is at risk for infection and what are the behaviors that place them at risk. The CDC Guidance calls for "An HIV/AIDS epidemiologic profile that reflects the current and future epidemic in the jurisdiction (i.e., reported AIDS cases, projected AIDS cases, estimated HIV prevalence in defined populations, HIV incidence, HIV risk behaviors, and other information, such as sexually transmitted diseases (STDs), teen pregnancy, and drug use, needed to target and monitor HIV prevention efforts)."

To identify the populations in San Francisco who are currently at risk for HIV infection and to calculate future trends within these populations, a wide variety of HIV-related epidemiologic data must be assembled. As the epidemic impacts communities who have been traditionally under served by the health care system, it is unlikely that any one source of data will present a complete picture of the scope of the epidemic on a city-wide basis. Moreover, viewing existing data from multiple perspectives is essential in understanding the influence that variables such as age, race/ethnicity, gender, socioeconomic status, sexual orientation and risk behaviors have on the spread of the virus within different communities. Indeed, the CDC guidance states that "in defining at-risk populations, special attention should be paid to distinguishing the behavioral, demographic and racial/ethnic characteristics."

Some communities, such as the gay community, have been studied continuously and intimately since the early days of the epidemic, and in that community reliable data concerning incidence, prevalence and behaviors is readily available. However, the HIV/AIDS epidemic has not only tightened its grip on the groups first identified as being at risk, namely self-identified gay men and injection drug users, but has also moved swiftly into communities of color, among women of all racial/ethnic backgrounds, and has emerged as a significant health threat to young people, both gay and straight.

To assemble a comprehensive picture of the epidemic in San Francisco, city-wide social and demographic data, AIDS case data (observed and projected), estimated seroprevalence data, published seroprevalence and seroincidence studies, counseling and testing data, surrogate marker data (STDs, Teen Pregnancy, TB and Substance Abuse), published behavioral studies and program and community level KABBs were gathered and analyzed according to the twelve transmission risk groups that were developed by the epidemiologic committee and approved by the full HPPC Council. These transmission groups emphasize the need to organize epidemiologic data and characterize the risk of infection based on behavior rather than the traditional "risk" groups that have been used in the past.

HPPC Transmission Groups

Population	Abbreviation
• Women who have Sex with Women	(WSW)
• Women who have Sex with Women and Inject Drugs	(WSW-IDU)
• Women who have Sex with Men and Women	(WSM & W)
• Women who have Sex with Men and Women and Inject Drugs	(WSM & W - IDU)
• Women who have Sex with Men	(WSM)
• Women who have Sex with Men and Inject Drugs	(WSM - IDU)
• Men who have Sex with Women	(MSW)
• Men who have Sex with Women and Inject Drugs	(MSW - IDU)
• Men who have Sex with Men and Women	(MSM & W)
• Men who have Sex with Men and Women and Inject Drugs	(MSM & W-IDU)
• Men who have Sex with Men	(MSM)
• Men who have Sex with Men and Inject Drugs	(MSM - IDU)

Each transmission group was further broken down by race/ethnicity and age. The approved age range for youth and young adults was 13 - 26 years. In addition, individuals from 27 to 29 years old were analyzed separately for AIDS case data (because of the ten year average incubation period). Populations such as transgenders, homeless populations, immigrants, populations in the sex industry, non-injection drug users, and partners of injection drug users were also analyzed with existing data. When possible, geographic and neighborhood distribution in epidemiologic data was assessed.

Collecting and analyzing data from multiple sources allows for the detection of the epidemic in areas and among populations that may be overlooked when only a few traditional sources of information and methods are used. However, even using the aforementioned data sources may not be sufficient in completely understanding the impact the disease is having on very specific population groups, such as transgendered people and immigrants. Therefore, some populations will deserve more comprehensive research before sound conclusions and recommendations can be made.

In addition, specific information of socioeconomic status, further breakdown within racial/ethnic populations (i.e., different Latino / Hispanic populations), and information on both sexual orientation *and* sexual behavior was missing from most data sources. The future data needs and methods for data collection that were generated by the Epidemiologic Profile / Needs Assessment committee during the development of this epidemiologic profile are listed at the beginning of this chapter. Hopefully, expanding data collection methods to include standardized behavioral and sociodemographic variables, will present a more reliable and complete picture of the epidemic throughout the city of San Francisco in the future.

HPPC FUTURE DATA NEEDS

In compiling the Epidemiologic Profile, several data needs became apparent to the Epidemiologic Profile / Needs Assessment committee. Although existing epidemiologic data provides a reasonably reliable picture of where the epidemic has been in San Francisco for traditional risk groups, comprehensive data that goes beyond traditional risk groups and defines populations by their risk behaviors (elucidating socio-demographic differences) is generally missing from most data sources.

An immediately identifiable need is for an expansion and standardization of data collection methods to include standardized behavioral and sociodemographic variables which, when combined with comprehensive prevalence and incidence data, will present a more reliable and complete picture of the epidemic in San Francisco.

SOCIAL AND DEMOGRAPHIC DATA

- New population estimates for: gay men, bisexual men, lesbian women, and bisexual women are greatly needed. These estimates should include a stratification by race/ethnicity and age.
- Estimates on the size and demographic makeup of legal and illegal immigrant populations in San Francisco are needed.
- Estimates on size and demographic makeup of transgender populations are needed.
- Estimates on demographic makeup and size of homeless populations (sheltered and unsheltered) are needed.
- There is a need for further breakdown of Latino, Black, and Asian / Pacific Islander populations.
- A category for bi-cultural populations should be added to demographics.

AIDS CASE REPORTING

- Data on sexual orientation *and* sexual behavior needs to be consistently collected and analyzed (sexual identity is not always congruent with sexual behavior).
- Transgender should be added as a demographic variable.
- Non-IDU drug use should be collected as a risk variable.
- Gay and bisexual men should not always be combined, analyzed, and reported as one group.
- Lesbian and bisexual women should not always be combined, analyzed and reported as one group.

- The collection and reporting of multiple risk behaviors, rather than the mutually exclusive hierarchical system of risk categories is encouraged (i.e., injection drug use *and* sexual behavior).
- Socioeconomic variables need to be standardized and included in AIDS case data reporting (i.e., income, education level, occupation, health insurance, neighborhood block).
- Criteria for physician reporting needs to be updated and standardized.

PREVALENCE AND INCIDENCE

- Data on sexual orientation *and* sexual behavior needs to be consistently collected and analyzed in prevalence & incidence studies.
- Transgender with its sub-categories should be added as a demographic variable to prevalence and incidence data.
- Non-IDU drug use should be collected as a risk variable.
- Gay and bisexual men should not always be combined, analyzed, and reported as one group.
- Lesbian and bisexual women should not always be combined, analyzed and reported as one group.
- The collection and reporting of multiple risk behaviors, rather than the mutually exclusive hierarchical system of risk categories is encouraged when looking at prevalence and incidence data.
- Socioeconomic variables need to be standardized and included in seroprevalence and incidence studies (i.e., income, education level, occupation, health insurance, neighborhood block).
- There is a need to stop combining different racial / ethnic groups into an "other" category, especially when this category has high prevalence rates.
- Although population based studies are valuable and should continue, there is also a need for studies which over sample minority populations (targeted sampling) for Native Americans and Asian/Pacific Islanders.
- Lesbian and bisexual women should not be combined into the heterosexual category in prevalence studies just because they have sex with men.
- San Francisco needs longer cohort studies to get more incidence data on high risk populations.
- There is a need for more sampling of young gay men that does not rely so heavily on bars, sex clubs and discos.
- When looking at racial/ethnic differences in prevalence data, there is a need to stratify by injection drug use and other drug use.

Recommendations for Future Prevalence and Incidence Studies:
(Not Ranked in Order)

1) Transgender populations
2) Recent Immigrants (documented and undocumented)
3) Female partners of bisexual men
4) Young IDUs (street based sample; new initiates)
5) Traditionally understudied racial/ethnic populations (Native American and Asian / Pacific Islanders)
6) Young gay men of color
7) Lesbian (self-identified) IDUs
8) Non-IDU partners of IDUs
9) Out of school youth (street based samples)
10) Populations diagnosed w/ a Sexually Transmitted Disease (STD) other than HIV (i.e., Seattle studies that follow those diagnosed w/ a STD)
11) Non-IDU substance using gay, bisexual and heterosexual populations (including youth)
12) Street based samples of non-IDU substance using populations
13) Populations in the sex industry (including transgenders, street youth, and immigrants and refugees who work in massage parlors).

BEHAVIORAL DATA

- There is a great need to standardize and update behavioral variables in San Francisco. This would facilitate program level evaluation, tracking behaviors over time and population comparisons. Standardization should include some demographic, sexual behavior, alcohol/drug use behavior, and other psychosocial, contextual and cultural variables.
- Data on sexual orientation *and* sexual behavior needs to be consistently collected and analyzed.
- Transgender should be included as a demographic variable in behavioral studies.
- Non-IDU drug use should be collected as a risk variable in behavioral studies.
- Gay and bisexual men should not always be combined, analyzed, and reported as one group.
- Lesbian an bisexual women should not always be combined, analyzed and reported as one group.
- The collection and reporting of multiple risk behaviors, rather than the mutually exclusive hierarchical system of risk categories is encouraged (i.e., injection drug use *and* sexual behavior).

- Socioeconomic variables need to be standardized and included in behavioral studies (i.e., income, education level, occupation, health insurance, neighborhood block).
- There is a need to stop combining different racial / ethnic groups into "other" category, especially when this category has high risk behaviors.
- KABBs need to be updated, standardized and administered every few years to track behaviors over time.
- There should be some type of Behavioral Surveillance System in San Francisco to monitor sexual and drug use behaviors.
- The Youth Risk Behavior Survey needs to include questions about homosexuality and more specific sexual and drug use questions. Federal and State regulations should be changed to allow surveys to include more specific questions regarding sexual behaviors, including same-sex behaviors. Also, the AIDS Office should do a presentation on seroprevalence (i.e., Young Men's Survey) for the School District to convince them of the need to add more specific behavioral variables.

Recommendations for Future Behavioral Studies:
(Not ranked in order)

1) Transgender populations
2) Recent Immigrants (documented and undocumented)
3) Female partners of bisexual men
4) Young gay men of color
5) Lesbian (self-identified) IDUs
6) Young IUDs (street based sample; new initiates)
7) Non-IDU partners of IDUs
8) Out of school youth. A standardized survey (similar to YRBS) should be conducted with out of school youth for comparison
9) There is a need for local population based behavioral studies of African Americans, Asian / Pacific Islanders, and Native Americans
10) Non-IDU substance using gay, bisexual and heterosexual populations (including youth)
11) Street based samples of non-IDU substance using populations
12) Populations in the sex industry (including transgenders, street youth, and immigrants and refugees who work in massage parlors).

SURROGATE MARKERS

- Studies that evaluate the utility and accuracy of using surrogate markers to predict HIV infection are needed.
- Data on sexual orientation *and* sexual behavior needs to be consistently collected and analyzed in surrogate marker studies.
- Transgender should be included as a demographic variable when collecting data on surrogate markers.
- Non-IDU drug use should be collected as a risk variable.
- Gay and bisexual men should not always be combined, analyzed, and reported as one group.
- Lesbian and bisexual women should not always be combined, analyzed and reported as one group.
- The collection and reporting of multiple risk behaviors, rather than the mutually exclusive hierarchical system of risk categories is encouraged (i.e., injection drug use and sexual behavior).
- Socioeconomic variables need to be standardized and included in surrogate marker studies (i.e., income, education level, occupation, health insurance, neighborhood block).
- There is a need for further breakdown of Latino, Black, and Asian / Pacific Islander populations.
- A category for bi-cultural populations should be added to demographics.
- There is a need to stop combining different racial / ethnic groups into "other" category, especially when this category appears to be high risk.
- Site specific data on surrogate markers needs to be evaluated (i.e., STDs among youth at Larkin Street Youth Center vs. Youth Guidance Center)
- City level programs need to standardize and coordinate data collection (i.e., AIDS Office, STD Control Program, TB Control Program, Hepatitis B Program, Community Substance Abuse Services)

INVISIBLE POPULATIONS
(Populations with little or no data available)

1. Transgender populations.
2. Immigrant populations (Asian/PI, Latino/Hispanic, Eastern European).
3. Homeless populations (in shelters, Single Room Occupancy hotels (SROs) and on the streets).
4. Mentally disabled.
5. Physically disabled (blind, hearing impaired).

DATA COLLECTION STANDARDIZATION

1. Criminal justice systems
2. College and school systems
3. Community Based Organizations (KABBs, needs assessments, evaluations etc.)
4. San Francisco Department of Public Health programs (Community Substance Abuse Services, STD Control, AIDS Office, TB Control Program, Hepatitis B, Community Substance Abuse Services).

SOCIAL AND DEMOGRAPHIC DATA

General Demographics

Between 1980 and 1990, San Francisco's population grew 6.6% (1). The Association of Bay Area Governments (ABAG) estimates that the city's population will climb by about 43,300 people between 1990 and 1995, resulting in a population of 771,300 (2). Although sexual orientation is not assessed in Census data, it is commonly estimated that 14% of the population is gay or lesbian. The estimate of gay/bisexual men most often used is 8% of the population, which would leave 6% of the population as lesbian or bisexual women (3). It is estimated that there are 16,000 Injection Drug Users (IDUs) in San Francisco (4).

According to 1990 Census data, the racial/ethnic breakdown of San Francisco is as follows:

46.8% of the population is non-Hispanic White, 10.6% non-Hispanic African American, 28.7% non-Hispanic Asian / Pacific Islander (18% Chinese; 6% Filipino; 2% Japanese; 2% South East Asian; 1% Korean; .4% Pacific Islander; and .4% other), 13.3% Hispanic/Latino, and .4% Native American/Alaska Native (5).

Between 1980 and 1990 there was an increase in population growth of Asian/Pacific Islanders and Latino/Hispanics (41% and 15%, respectively). Neighborhoods with the most growth in Asian Pacific Islanders were: Bayview/Hunter's Point, Ingleside, South Central, Outer Sunset, Tenderloin/Civic Center and Inner Sunset. Neighborhoods with the most growth in Latino/Hispanic populations were: Bayview/Hunter's Point, Tenderloin/Civic Center, Western Addition, Mission and South Central. It is not known how many recent immigrants contributed to this growth.

Immigrants

According to Census data, San Francisco's population is 28% foreign born, with 17% of immigrants arriving between 1987 and 1990 (this number does not include undocumented workers). Results from the 1993 San Francisco Unified School District Youth Risk Behavior Survey (YRBS) showed that 16% of all students surveyed had lived in the United States for 3 years or less (6). Statistics on undocumented immigration vary greatly due to the lack of accurate tracking by any governmental agency or organization. Discussions

with community leaders and reviews of the literature on immigrant and refugee communities indicate that China, Hong Kong, the Philippines and Latin America (specifically Central America and Mexico) currently provide the largest numbers of undocumented immigrants to San Francisco (7).

Language

According to Census data, 10% of the population 18 years or older (62,621) speak Spanish, and of these, 30% have limited or no English proficiency. The Asian or Pacific Island languages are spoken by 24% (142,820) of the population, and of these 39% have limited or no English proficiency (8). About 28.3% of San Francisco Unified School District students have limited or no English proficiency (9).

Poverty

The unemployment rate in the city and county of San Francisco is 7.1%, and is higher than the surrounding counties of Alameda, Contra Costa, Marin, and San Mateo (10). According to 1989 income tax returns, 31% of the population reported annual incomes under $12,000, and 13% were living below the poverty level (11). When looking at racial/ethnic differences in the percent total of per capita income ($19,695), the uneven distribution of wealth in San Francisco is apparent (12).

Race/Ethnicity	Income	% total
White	$26,222	133.3%
African American	$11,829	60.1%
Native American / Alaska Native	$11,485	58.3%
Asian / Pacific Islander	$12,665	64.3%
Latino / Hispanic	$11,400	57.9%
Other	$10,174	51.7%

The Census track areas in San Francisco with very low income concentration coincide most frequently with neighborhoods that are made up of primarily African American, Asian/Pacific Islander, and Latino/Hispanic populations. In addition, there are 15,641 residents living in a total of 47 public housing projects in San Francisco (1). About half of all of these residents are African American, 23% are Asian/Pacific Islander, 10% are Latino/Hispanic, and 12% are White. There are an additional 9,085 families and individuals on a waiting list for public housing. Currently, there are 4,026 public housing

families in San Francisco with an average of 3.3 members and an income of $9,199. Of all families in housing projects, 78% are headed by single parents (1).

Overall, 21% of San Francisco households are headed by women and 20% of all children live on AFDC (both of these are higher than the national levels of 16% and 12% respectively; 9).

Homelessness

The homeless population in San Francisco is not made up of any single category of people that can be located and counted on a given night. The past, "snap shot" views of homelessness generated by the Census data and other estimates ranged from 6,000 to 8,000. These estimates are now considered out of date and extremely low. The 1994 Comprehensive Housing Affordability Strategy (CHAS) report estimates that the current homeless population of the City is approximately 11,000 to 16,000 people. This estimate is based on the estimated number of people homeless on a given night (in shelters, transitional housing, outdoors, in vehicles and those who are institutionalized, but have no home to return to). It also takes into account the number of people who experience an episode of homelessness during the course of a year, and indicators of trends in the level of homelessness and poverty over time, such as changes in the numbers turned away from shelters.

The number of shelter beds in San Francisco is about 2,000 and each night approximately 500 people are turned away (13). Families now represent about 25-30% of the homeless population, but only 14% of the beds in shelters are available to families with children (14). In the month of June 1993, 1,502 families were turned away from shelters. Furthermore, between July 1992 and June 1993, more than 2,000 women and children who were homeless as a result of domestic violence and abuse were turned away from the 45 beds in two emergency shelters specifically set aside for those escaping abusive home situations (14).

According to the Division of Mental Health and Substance Abuse, 30-40% of homeless people nationwide are mentally ill. A 1992 study in San Francisco found that many mentally disabled homeless people are unable or unwilling to access emergency shelters, making them a very difficult population to reach (14). The San Francisco Department of Public Health estimates that 40-50% of homeless in San Francisco are substance abusers. Although there is limited information available on the extent of the dual diagnosis of mental

illness and alcohol/drug addiction, a 1992 survey of homeless individuals in the Transbay Terminal found that 59% had a mental disability and 14% of those who were mentally disabled also had substance abuse problems.

Out of School Youth

The Homeless and Runaway Youth Network estimates that there are 2,000 homeless/runaway youth in San Francisco which is consistent with the State Comprehensive Homeless Assistance Plan's estimation that 5-10% of the homeless statewide were runaway youths. The San Francisco School District uses a cohort system to track students and has found the cumulative drop-out rate over the four years of high school to be 16.4% (3,475). The high school drop-out rate is even higher among African Americans (24.2%) and those with a Spanish surname (23.6%).

Incarcerated Adults

The state of California has the greatest number of inmates incarcerated in the United States with over 100,000 presently in custody. As of July 31, 1994 there were 246 female and 2,208 male paroles in San Francisco (California Department of Corrections). There is not a state prison in San Francisco, however, there are four San Francisco County Jails. According to the San Francisco Sheriff's Department (June, 1994), the average daily census of the San Francisco jails is 2,400, up 11.4% from the previous year. Ninety percent of the inmates are male, and 10% female. The recidivism rate is predicted to be 55%. The population is mainly comprised of ethnic and racial minorities: 50.2% African American, 27.4% Hispanic, 19.4% European American, 1.6% Asian and 1.2% Native American and Samoan (15).

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CITY-WIDE POPULATION ESTIMATES

When reviewing epidemiologic data for HIV prevention planning, it is useful to know the size of different population and transmission groups. Census data gives a view of gender, age, and race/ethnicity, but no information on sexual orientation. Populations based on sexual and drug using behaviors must be generated by estimates and published research findings.

Methodology

Population Estimates

Overall population estimates were derived from the 1990 Census, Population and Housing Statistics. The city-wide 1990 estimate of adults and adolescents 13 years and older is 638,893. The Census Bureau does not report "Latino/ Hispanic" as a separate racial group. Therefore, population estimates for Latinos and Hispanics are determined by adding those who report "Hispanic Origin" from other racial groups, including "Other" race. A summary of those reporting Hispanic Origin by race is shown below:

Hispanic Origin?	African American	Asian/Pac. Islander	Native American	White	Other Race
Yes	1,606	3,055	642	45,320	35,121
No	62,661	176,676	2,287	311,525	**
Total	64,267	179,731	2,929	356,845	35,121

** non-Hispanic "Other" race were excluded from the City-Wide population estimates.

The reported population estimates of African Americans, Asian/Pacific Islanders, Native Americans, and Whites are non-Hispanic, that is, those who did not report Hispanic origin. Latino/Hispanic ethnicity is then reported as a racial category. However, the 1990 Census probably

underestimates particular population groups (i.e., homeless adults and youth, immigrants, and some non-white populations).

Transmission Group Estimates

Transmission group estimates were derived from previous reports and studies conducted in San Francisco. The majority of these reports utilize commonly reported transmission groups, such as Gay/Bisexual Men, Injection Drug Users (IDUs) and Heterosexuals. For this plan, however, population estimates for more specific transmission groups were required. The transmission groups approved by the Council emphasize a need to characterize the risk for infection based on behavior rather than "risk" group alone. Therefore, traditional risk groups were re-configured to reflect sexual and blood exposure. The diagram below shows the traditional "Risk" groups, and the transmission groups approved by the HIV Prevention Planning Council (HPPC).

Traditional Risk Groups		HPPC Transmission Groups
Gay/Bisexual Men	-->	Men Who Have Sex with Men (MSM)
	-->	Men Who Have Sex with Men and Women (MSM&W)
Gay/Bisexual Men - IDUs	-->	Men Who Have Sex with Men - IDUs (MSM-IDU)
	-->	Men Who Have Sex with Men and Women - IDUs (MSM&W-IDU)
Other IDUs	-->	Men Who Have Sex with Women - IDUs (MSW-IDU)
	-->	Women Who Have Sex with Men - IDUs (WSM-IDU)
	-->	Women Who Have Sex with Men and Women - IDUs (WSM&W-IDU)
	-->	Women Who Have Sex with Women - IDUs (WSW-IDU)
Other Adults	-->	Men Who Have Sex with Women (MSW)
	-->	Women Who Have Sex with Women (WSW)
	-->	Women Who Have Sex with Men and Women (WSM&W)
	-->	Women Who Have Sex with Men (WSM)

The 1993 Race/Ethnicity Consensus report did provide population estimates for traditional risk groups by race/ethnicity. These estimates are shown below:

Population Estimates for Gay/Bisexual Men and Injection Drug Users by Race/Ethnicity, 1993 Consensus Report

Risk Group	African American	Asian/Pac. Islander	Latino/ Hispanic	Native American	White
Gay/Bisexual Men					
Non-IDUs	5,506	5,792	7,802	322	35,578
IDUs	300	316	426	18	1,941
Sub-Total	5,806	6,107	8,228	340	37,519
IDUs					
Heterosexual Men	2,961	472	977	77	3,979
Women	1,568	250	517	41	2,106
Sub-Total	4,529	722	1,494	118	6,085
Total	10,335	6,829	9,722	458	43,604

The 1992 Consensus Report risk group population estimates were based on a composite of distributions from several studies and reports. The composite estimate for gay and bisexual men used the following sources: 1) reported AIDS cases in 1992; 2) a random digit-dial survey of gay and bisexual men conducted by Communications Technologies (1990); 3) the racial and ethnic distributions from Young Men's Survey (1992/93), 4) the unlinked seroprevalence survey at a STD Clinic (City Clinic 1991); and 5) the 1990 Census.

Similarly, to estimate the racial/ethnic distribution of IDUs, the consensus report used a second composite from the following sources: 1) reported AIDS cases among IDUs in 1992; 2) population-based household surveys of African Americans (Polaris Research & Development, 1989), Latinos (Fairbank, Bregman and Maullin, 1989), Filipinos (The Asian American Health Forum/Filipino Task Force on AIDS, 1990), Chinese (Asian American Recovery Services, 1990), Japanese (Asian American Recovery Services, 1990), and Southeast Asians (Center for Southeast Asian Refugee Resettlement,

1991); 3) unduplicated counts of clients in drug treatment (Community Substance Abuse Services, SFDPH, 1990-91); 4) unlinked HIV seroprevalence surveys at methadone clinics in San Francisco (1989-92); 5) street-based surveys of IDUs (Urban Health Study, 1991-92); and 6) The 1990 census.

From these composite reports, we use the following population estimates for Gay and Bisexual men: 55,000 non-IDUs and 3,000 IDUs. For non-gay IDUs, we use the following population estimates: 8,500 heterosexual men, and 4,500 women.

Estimates of the total number of other adults and adolescents (women and heterosexual men) are calculated by subtracting the population size estimates from Gay and Bisexual Men and IDUs from the remaining number of adults and adolescents in San Francisco. These calculations are shown in the following table:

Population Estimates for Other Adults and Adolescents by Race/Ethnicity, 1993 Consensus Report

Risk Group	African American	Asian/Pac. Islander	Latino/ Hispanic	Native American	White
Remaining Adult Population in SF	62,661	176,676	85,744	2,287	311,525
Gay/Bisexual Men	- 5,806	- 6,107	- 8,228	- 340	- 37,519
IDUs	- 4,529	- 722	- 1,494	- 118	- 6,085
Other Adults	52,326	169,847	76,022	1,829	267,921

No reports are available which estimate the number of Lesbian and Bisexual Women. Therefore we used a widely circulated, but unsubstantiated estimate of 10% of the adult female population has sex with women, or approximately 31,500. This plan uses this estimate.

These population estimates were used as a basis to re-configure the past risk groups to the HPPC approved transmission groups. Transmission groups can be collapsed to yield the original "risk" group. For example, to obtain

population estimates of non-IDU Gay and Bisexual men, it is necessary to combine the men MSM and MSM&W groups.

Since there are no adequate estimates of "Risk" by age or age-group, this methodology assumes a standard age-structure. These estimates uses the City-Wide age distribution as the standard. Therefore, the same age-group percentages are used for all transmission categories. The City-Wide Age-group distribution is shown below:

Age Group Distribution

Age Group (Years)	Female	Male
13 - 26	21.0%	21.5%
27 - 29	7.5%	8.0%
30+	71.5%	70.5%
Total	100.0%	100.0%

The following assumptions were used to obtain the size of bisexual populations (MSM&W and WSM&W): From the Young Men's Survey, 25% of MSMs had sex with a women during the previous 6 months. Therefore, we assume the population sizes of MSM&W and MSM&W-IDU to be a quarter of the MSM and MSM-IDU populations. From the 1992 Women's Survey, 52% of WSW also had sex with a man during the previous 3 years. Therefore, we assume that the 52% of WSW as WSM&W. Also from the 1992 Women's Survey, among WSW, 3.8% had injected drugs during the previous 3 years. Therefore we estimate that 3.8% of WSW and WSM&W were injection drug users. Unfortunately, there are no San Francisco studies that show the number of heterosexual men or women who have sex with a same sex partner.

City-Wide Population Estimates

All Adults and Adolescents 13 Years and Older

	Females	Males	Total
Overall Total:	**319,849**	**319,044**	**638,893**
Sub-populations:			
Age Group			
13 - 26 Years Old	67,168	67,957	135,125
27 - 29 Years Old	23,989	24,566	48,555
30+ Years Old	228,692	226,521	455,213
Total:	**319,849**	**319,044**	**638,893**
Race / Ethnicity			
African American (Non-Hispanic)	31,843	30,818	62,661
Asian / Pacific Isl. (Non-Hispanic)	93,128	83,548	176,676
Latino / Hispanic	41,766	43,978	85,744
Native American (Non-Hispanic)	1,097	1,190	2,287
White / Caucasian (Non-Hispanic)	152,015	159,510	311,525
Total:	**319,849**	**319,044**	**638,893**

NOTE: The sum of all categories may not add to the total, due to rounding.

City-Wide Population Estimates

All Adults and Adolescents 13 Years and Older

	Estimated Pop. Size	% of SF Population
Overall Total:	**638,893**	**100.00%**
Transmission Groups:		
Women who Have. . .		
. . .Sex with Women	14,550	2.28%
. . .Sex with Women - IDU	575	0.09%
. . .Sex with Men and Women	15,750	2.47%
. . .Sex with Men and Women - IDU	625	0.10%
. . .Sex with Men	285,049	44.62%
. . .Sex with Men - IDU	3,300	0.52%
Sub-Total:	**319,849**	**50.06%**
Men who Have. . .		
. . .Sex with Women	252,544	39.53%
. . .Sex with Women - IDU	8,500	1.33%
. . .Sex with Men and Women	13,750	2.15%
. . .Sex with Men and Women - IDU	750	0.12%
. . .Sex with Men	41,250	6.46%
. . .Sex with Men - IDU	2,250	0.35%
Sub-Total:	**319,044**	**49.94%**

NOTE: The sum of all categories may not add to the total, due to rounding.

City-Wide Population Estimates

All Adults and Adolescents 13 Years and Older

	13-26 Years	27-29 Years	30+ Years	Total
Overall Total:	**135,125**	**48,555**	**455,213**	**638,893**
Transmission Groups:				
Women who Have. . .				
. . .Sex with Women	3,056	1,091	10,403	14,550
. . .Sex with Women - IDU	121	43	411	575
. . .Sex with Men and Women	3,308	1,181	11,261	15,750
. . .Sex with Men and Women - IDU	131	47	447	625
. . .Sex with Men	59,860	21,379	203,810	285,049
. . .Sex with Men - IDU	693	248	2,360	3,300
Sub-Total:	**67,168**	**23,989**	**228,692**	**319,849**
Men who Have. . .				
. . .Sex with Women	53,792	19,446	179,306	252,544
. . .Sex with Women - IDU	1,811	655	6,035	8,500
. . .Sex with Men and Women	2,929	1,059	9,763	13,750
. . .Sex with Men and Women - IDU	160	58	533	750
. . .Sex with Men	8,786	3,176	29,288	41,250
. . .Sex with Men - IDU	479	173	1,598	2,250
Sub-Total:	**67,956**	**24,566**	**226,521**	**319,044**

NOTE: The sum of all categories may not add to the total, due to rounding.

City-Wide Population Estimates

All Adults and Adolescents 13 Years and Older

	African American	Asian/ Pacific Isl.	Latino/ Hispanic	Native American	White
Overall Total:	**62,661**	**176,676**	**85,744**	**2,287**	**311,525**
Transmission Groups:					
Women who Have. . .					
. . .Sex with Women	1,449	4,236	1,900	50	6,915
. . .Sex with Women - IDU	199	29	75	5	273
. . .Sex with Men and Women	1,568	4,586	2,056	54	7,486
. . .Sex with Men and Women - IDU	217	34	82	5	297
. . .Sex with Men	27,258	84,056	37,294	952	135,508
. . .Sex with Men - IDU	1,152	187	360	30	1,535
Total:	**31,843**	**93,128**	**41,766**	**1,097**	**152,015**
Men who Have. . .					
. . .Sex with Women	22,051	76,968	34,774	774	118,013
. . .Sex with Women - IDU	2,961	472	977	77	3,979
. . .Sex with Men and Women	1,376	1,448	1,950	80	8,894
. . .Sex with Men and Women - IDU	75	79	106	5	485
. . .Sex with Men	4,130	4,344	5,852	241	26,683
. . .Sex with Men - IDU	225	237	319	13	1,456
Total:	**30,818**	**83,548**	**43,978**	**1,190**	**159,510**

NOTE: The sum of all categories may not add to the total, due to rounding.

AIDS CASE DATA

Introduction

AIDS case data is a useful source of information about past HIV infection in San Francisco. The average time from infection with HIV to the development of an AIDS defining condition is estimated to be approximately ten years in men who have sex with men. Because of this long delay, this data provides a profile of populations infected approximately ten years ago rather than populations currently being infected.

In 1993, the AIDS case definition changed to include more illnesses experienced by women with HIV, people with HIV and tuberculosis, and all HIV infected individuals with CD4 counts below 200 cells (or 14%). Although AIDS case reporting in San Francisco is thought to capture most AIDS cases, under reporting of certain populations may occur (i.e., homeless populations or self-identified heterosexual men who have sex with men). While realizing the aforementioned limitations, the San Francisco HIV Prevention Planning Council decided AIDS case data is important to include in an epidemiologic profile because it does provide important information regarding changes over time (i.e., potential trends).

Methodology

Reported AIDS Cases

The San Francisco Department of Public Health AIDS Office analyzed all reported adult AIDS cases for the City and County of San Francisco for the period 1989 to 1993. All cases due to sexual transmission and/or injection drug use were re-classified into one of eight transmission categories approved by the HIV Prevention Planning Council.

1. Women who have sex with women (includes lesbian and bisexual women)
2. Women who have sex with women and inject drugs (includes lesbian and bisexual women)
3. Women who have sex with men
4. Women who have sex with men and inject drugs
5. Men who have sex with women
6. Men who have sex with women and inject drugs
7. Men who have sex with men (includes gay and bisexual men)
8. Men who have sex with men and inject drugs (includes gay and bisexual men)

The four year period 1989 to 1993 was chosen to capture the most recent infections that can be provided from this data while providing a sufficient number of cases to accurately estimate the proportionate effect within each transmission group. Cases in each of the transmission groups are separately tabulated by recorded race and age at time of diagnosis.

Projected AIDS Cases

Projected AIDS cases for 1994 to 1997 were estimated by the San Francisco Department of Public Health AIDS Office, Seroepidemiology and Surveillance Branch. Estimates of progression to AIDS were made using seroconversion rates combined with a log-logistic extrapolation of Kaplan-Meier estimates for progression to AIDS. For populations with very small sample size or very low numbers of AIDS cases, projections were not made, and are indicated in the following pages with an asterisk (*).

Case Rate Assumptions

To examine the proportional effect of AIDS in each of the transmission groups by race/ethnicity, 1990 Census data was used to calculate the relative size of each racial/ethnic group. The racial/ethnic distribution among each of the transmission categories was assumed proportional to the Census. For example, the percentage of men who have sex with men is assumed to be constant across each race.

While this assumption may appear naive, it was necessary because of the lack of consensus regarding racial/ethnic variation in sexual behavior. For this reason, the estimated rate per 100,000 may be over or under the actual rate. Additionally, in the case of Native Americans, the Census population size is sometimes smaller than the number of AIDS cases reported. For example, among Native American men who have sex with men and inject drugs, this case rate assumption results in a rate greater than 100,000 in both Observed AIDS Cases and Projected AIDS Cases.

All case rates shown below should not be quoted as precise, and should only be used for relative comparison purposes.

Women Who Have Sex With Women

	Observed Cases 1989 - 1993			Projected Cases 1994 - 1997		
	No. of Cases	No. of Cases Per 100,000	% of Total Cases	No. of Cases	No. of Cases Per 100,000	% of Total Cases
Overall Total:	0	0	*	*	*	*
Sub-populations:						
Race / Ethnicity						
African American	0	*	0.0%	*	*	*
Asian / Pacific Isl. (See Detail Below)	0	*	0.0%	*	*	*
Latina	0	*	0.0%	*	*	*
Native American	0	*	0.0%	*	*	*
White / Caucasian	0	*	0.0%	*	*	*
Total:	0	*	0.0%	*	*	*
Asian / Pacific Isl. Ethnicity						
Chinese	0	*	*	*	*	*
Filipina	0	*	*	*	*	*
Hawaiian / Pacific Islander	0	*	*	*	*	*
Japanese	0	*	*	*	*	*
Korean	0	*	*	*	*	*
Southeast Asian	0	*	*	*	*	*
Other Asian	0	*	*	*	*	*
Total:	0	*	*	*	*	*
Age Group						
13 - 26 Years Old	0	*	0.0%	*	*	*
27 - 29 Years Old	0	*	0.0%	*	*	*
30+ Years Old	0	*	0.0%	*	*	*
Total:	0	*	0.0%	*	*	*

* = Insufficient data available.
N/A = Not Applicable. (Rates cannot be totaled.)

Women Who Have Sex With Women - IDUs

	Observed Cases 1989 - 1993			Projected Cases 1994 - 1997		
	No. of Cases	No. of Cases Per 100,000	% of Total Cases	No. of Cases	No. of Cases Per 100,000	% of Total Cases
Overall Total:	**6**	**500**	**100.0%**	*	*	*
Sub-populations:						
Race / Ethnicity						
African American	3	765	50.0%	*	*	*
Asian / Pacific Isl. (See Detail Below)	0	0	0.0%	*	*	*
Latina	0	0	0.0%	*	*	*
Native American	0	0	0.0%	*	*	*
White / Caucasian	3	570	50.0%	*	*	*
Total:	**6**	**N/A**	**100.0%**	*	*	*
Asian / Pacific Isl. Ethnicity						
Chinese	0	*	0.0%	*	*	*
Filipina	0	*	0.0%	*	*	*
Hawaiian / Pacific Islander	0	*	0.0%	*	*	*
Japanese	0	*	0.0%	*	*	*
Korean	0	*	0.0%	*	*	*
Southeast Asian	0	*	0.0%	*	*	*
Other Asian	0	*	0.0%	*	*	*
Total:	**0**	*	**0.0%**	*	*	*
Age Group						
13 - 26 Years Old	0	0	0.0%	*	*	*
27 - 29 Years Old	0	0	0.0%	*	*	*
30+ Years Old	6	699	100.0%	*	*	*
Total:	**6**	**N/A**	**100.0%**	*	*	*

* = Insufficient data available.
N/A = Not Applicable. (Rates cannot be totaled.)

Women who Have Sex with Men

	Observed Cases 1989 - 1993			Projected Cases 1994 - 1997		
	No. of Cases	No. of Cases Per 100,000	% of Total Cases	No. of Cases	No. of Cases Per 100,000	% of Total Cases
Overall Total:	126	44	100.0%	*	*	*
Sub-populations:						
Race / Ethnicity						
African American	38	134	30.2%	*	*	*
Asian / Pacific Isl. (See Detail Below)	10	12	7.9%	*	*	*
Latina	21	56	16.7%	*	*	*
Native American	2	204	1.6%	*	*	*
White / Caucasian	55	41	43.6%	*	*	*
Total:	126	N/A	100.0%	*	*	*
Asian / Pacific Isl. Ethnicity						
Chinese	2	*	1.6%	*	*	*
Filipina	5	*	3.9%	*	*	*
Hawaiian / Pacific Islander	1	*	0.8%	*	*	*
Japanese	1	*	0.8%	*	*	*
Korean	1	*	0.8%	*	*	*
Southeast Asian	0	*	0.0%	*	*	*
Other Asian	0	*	0.0%	*	*	*
Total:	10	*	7.9%	*	*	*
Age Group						
13 - 26 Years Old	14	23	11.1%	*	*	*
27 - 29 Years Old	22	103	17.5%	*	*	*
30+ Years Old	90	44	71.4%	*	*	*
Total:	126	N/A	100.0%	*	*	*

* = Insufficient data available.
N/A = Not Applicable. (Rates cannot be totaled.)

Women Who Have Sex with Men - IDUs

	Observed Cases 1989 - 1993			Projected Cases 1994 - 1997		
	No. of Cases	No. of Cases Per 100,000	% of Total Cases	No. of Cases	No. of Cases Per 100,000	% of Total Cases
Overall Total:	**214**	**6,485**	**100.0%**	**158**	**4,788**	**100.0%**
Sub-populations:						
Race / Ethnicity						
African American	108	9,184	50.4%	77	6,548	48.7%
Asian / Pacific Isl. (See Detail Below)	7	3,723	3.3%	4	2,127	2.5%
Latina	19	5,938	8.9%	15	4,688	9.5%
Native American	3	9,677	1.4%	0	0	0.0%
White / Caucasian	77	4,873	36.0%	62	3,924	39.3%
Total:	**214**	**N/A**	**100.0%**	**158**	**N/A**	**100.0%**
Asian / Pacific Isl. Ethnicity						
Chinese	1	*	0.5%	*	*	*
Filipina	1	*	0.5%	*	*	*
Hawaiian / Pacific Islander	3	*	1.4%	*	*	*
Japanese	0	*	0.0%	*	*	*
Korean	0	*	0.0%	*	*	*
Southeast Asian	1	*	0.5%	*	*	*
Other Asian	1	*	0.5%	*	*	*
Total:	**7**	*	**3.4%**	*	*	*
Age Group						
13 - 26 Years Old	13	1,876	6.1%	*	*	*
27 - 29 Years Old	21	8,468	9.8%	*	*	*
30+ Years Old	180	7,627	84.1%	*	*	*
Total:	**214**	**N/A**	**100.0%**	*	*	*

* = Insufficient data available.
N/A = Not Applicable. (Rates cannot be totaled.)

Men Who Have Sex With Women

	Observed Cases 1989 - 1993			Projected Cases 1994 - 1997		
	No. of Cases	No. of Cases Per 100,000	% of Total Cases	No. of Cases	No. of Cases Per 100,000	% of Total Cases
Overall Total:	25	10	100.0%	*	*	*
Sub-populations:						
Race / Ethnicity						
African American	8	33	32.0%	*	*	*
Asian / Pacific Isl. (See Detail Below)	2	3	8.0%	*	*	*
Latino	5	14	20.0%	*	*	*
Native American	0	0	0.0%	*	*	*
White / Caucasian	10	8	40.0%	*	*	*
Total:	25	N/A	100.0%	*	*	*
Asian / Pacific Isl. Ethnicity						
Chinese	0	*	0.0%	*	*	*
Filipino	1	*	4.0%	*	*	*
Hawaiian / Pacific Islander	0	*	0.0%	*	*	*
Japanese	0	*	0.0%	*	*	*
Korean	0	*	0.0%	*	*	*
Southeast Asian	1	*	4.0%	*	*	*
Other Asian	0	*	0.0%	*	*	*
Total:	2	*	8.0%	*	*	*
Age Group						
13 - 26 Years Old	2	4	8.0%	*	*	*
27 - 29 Years Old	3	15	12.0%	*	*	*
30+ Years Old	20	11	80.0%	*	*	*
Total:	25	N/A	100.0%	*	*	*

* = Insufficient data available.
N/A = Not Applicable. (Rates cannot be totaled.)

Men Who Have Sex With Women - IDUs

	Observed Cases 1989 - 1993			Projected Cases 1994 - 1997		
	No. of Cases	No. of Cases Per 100,000	% of Total Cases	No. of Cases	No. of Cases Per 100,000	% of Total Cases
Overall Total:	644	7,576	100.0%	561	6,600	100.0%
Sub-populations:						
Race / Ethnicity						
African American	292	9,861	45.4%	205	6,923	36.6%
Asian / Pacific Isl. (See Detail Below)	6	1,271	0.9%	8	1,694	1.4%
Latino	90	9,212	14.0%	36	3,684	6.4%
Native American	2	2,598	0.3%	0	0	0.0%
White / Caucasian	254	6,384	39.4%	312	7,841	55.6%
Total:	644	N/A	100.0%	561	N/A	100.0%
Asian / Pacific Isl. Ethnicity						
Chinese	0	*	0.0%	*	*	*
Filipino	3	*	0.5%	*	*	*
Hawaiian / Pacific Islander	1	*	0.1%	*	*	*
Japanese	0	*	0.0%	*	*	*
Korean	0	*	0.0%	*	*	*
Southeast Asian	2	*	0.3%	*	*	*
Other Asian	0	*	0.0%	*	*	*
Total:	6	*	0.9%	*	*	*
Age Group						
13 - 26 Years Old	27	1,491	4.2%	*	*	*
27 - 29 Years Old	46	7,023	7.1%	*	*	*
30+ Years Old	571	9,461	88.7%	*	*	*
Total:	644	N/A	100.0%	*	*	*

* = Insufficient data available.
N/A = Not Applicable. (Rates cannot be totaled.)

Men Who Have Sex With Men

	Observed Cases 1989 - 1993			Projected Cases 1994 - 1997		
	No. of Cases	No. of Cases Per 100,000	% of Total Cases	No. of Cases	No. of Cases Per 100,000	% of Total Cases
Overall Total:	**9,738**	**17,705**	**100.0%**	**4,021**	**7,311**	**100.0%**
Sub-populations:						
Race / Ethnicity						
African American	738	13,893	7.6%	373	7,022	9.3%
Asian / Pacific Isl. (See Detail Below)	259	1,798	2.7%	114	792	2.8%
Latino	913	12,043	9.4%	435	5,738	10.8%
Native American	33	16,098	0.3%	20	9,756	0.5%
White / Caucasian	7,795	28,345	80.0%	3,079	11,196	76.6%
Total:	**9,738**	**N/A**	**100.0%**	**4,021**	**N/A**	**100.0%**
Asian / Pacific Isl. Ethnicity						
Chinese	82	*	0.8%	*	*	*
Filipino	93	*	1.0%	*	*	*
Hawaiian / Pacific Islander	17	*	0.2%	*	*	*
Japanese	27	*	0.3%	*	*	*
Korean	3	*	0.0%	*	*	*
Southeast Asian	19	*	0.2%	*	*	*
Other Asian	18	*	0.2%	*	*	*
Total:	**259**	*	**2.7%**	*	*	*
Age Group						
13 - 26 Years Old	350	2,988	3.6%	*	*	*
27 - 29 Years Old	655	15,466	6.7%	*	*	*
30+ Years Old	8,733	22,364	89.7%	*	*	*
Total:	**9,738**	**N/A**	**100.0%**	*	*	*

* = Insufficient data available.
N/A = Not Applicable. (Rates cannot be totaled.)

Men Who Have Sex With Men - IDUs

	Observed Cases 1989 - 1993			Projected Cases 1994 - 1997		
	No. of Cases	No. of Cases Per 100,000	% of Total Cases	No. of Cases	No. of Cases Per 100,000	% of Total Cases
Overall Total:	929	30,967	100.0%	309	10,300	100.0%
Sub-populations:						
Race / Ethnicity						
African American	135	45,000	14.5%	32	10,667	10.4%
Asian / Pacific Isl. (See Detail Below)	9	2,848	1.0%	1	316	0.3%
Latino	82	19,249	8.8%	51	11,972	16.5%
Native American	16	88,889"	1.7%	8	44,444"	2.6%
White / Caucasian	687	35,394	74.0%	217	11,180	70.2%
Total:	929	N/A	100.0%	309	N/A	100.0%
Asian / Pacific Isl. Ethnicity						
Chinese	0	*	0.0%	*	*	*
Filipino	3	*	0.3%	*	*	*
Hawaiian / Pacific Islander	2	*	0.2%	*	*	*
Japanese	3	*	0.3%	*	*	*
Korean	0	*	0.0%	*	*	*
Southeast Asian	0	*	0.0%	*	*	*
Other Asian	1	*	0.1%	*	*	*
Total:	9	*	0.9%	*	*	*
Age Group						
13 - 26 Years Old	75	11,737	8.1%	*	*	*
27 - 29 Years Old	92	39,827	9.9%	*	*	*
30+ Years Old	762	35,758	82.0%	*	*	*
Total:	929	N/A	100.0%	*	*	*

* = Insufficient data available.
N/A = Not Applicable. (Rates cannot be totaled.)
" = See explanation above, under "Case Rate Assumptions."

ESTIMATED HIV INFECTION

NOTE: The following population size estimates and estimates of HIV infection are approximations, and should be used for relative comparisons only.

In addition to AIDS case data, an overall estimate of the number of people infected in each of the transmission groups was constructed in order to elucidate a more current picture of HIV infection in San Francisco. The number of persons believed to be infected with HIV in San Francisco is approximately 28,000 (1992 Consensus Report).

The distribution of HIV infection by transmission group, age, and race/ethnicity is derived from current estimates of HIV prevalence from clinic, street, and population-based studies in San Francisco as well as "expert opinion" as reflected in the 1993 Consensus Report. Many of these reports and studies are compiled in a single document prepared for the HIV Prevention Planning Council titled: "Reports and Surveys Issued or Commissioned by the Seroepidemiology Branch, AIDS Office, San Francisco Department of Public Health".

Methodology

Population Estimates

Overall population estimates were derived from the 1990 Census, Population and Housing Statistics. The city-wide 1990 estimate of adults and adolescents 13 years and older is 638,893. The Census Bureau does not report "Latino/Hispanic" as a separate racial group. Therefore, population estimates for Latinos and Hispanics are determined by adding those who report "Hispanic Origin" from other racial groups, including "Other" race. A summary of those reporting Hispanic Origin by race is shown below:

Hispanic Origin?	African American	Asian/Pac. Islander	Native American	White	Other Race
Yes	1,606	3,055	642	45,320	35,121
No	62,661	176,676	2,287	311,525	**
Total	64,267	179,731	2,929	356,845	35,121

** non-Hispanic "Other" race were excluded from the City-Wide population estimates.

The reported population estimates of African Americans, Asian/Pacific Islanders, Native Americans, and Whites are non-Hispanic, that is, those who did not report Hispanic origin. Latino/Hispanic ethnicity is then reported as a racial category. However, the 1990 Census probably underestimates particular population groups (i.e., homeless adults and youth, immigrants, and some non-white populations).

Transmission Group Estimates

Transmission group estimates were derived from previous reports and studies conducted in San Francisco. The majority of these reports utilize commonly reported transmission groups, such as Gay/Bisexual Men, Injection Drug Users (IDUs) and Heterosexuals. For this plan, however, population estimates for more specific transmission groups were required. The transmission groups approved by the Council emphasize a need to characterize the risk for infection based on behavior rather than "risk" group alone. Therefore, traditional risk groups were re-configured to reflect sexual and blood exposure. The diagram below shows the traditional "Risk" groups, and the transmission groups approved by the Prevention Planning Council.

Traditional Risk Groups		HPPC Transmission Groups
Gay/Bisexual Men	-->	Men Who Have Sex with Men (MSM)
	-->	Men Who Have Sex with Men and Women (MSM&W)
Gay/Bisexual Men - IDUs	-->	Men Who Have Sex with Men - IDUs (MSM-IDU)
	-->	Men Who Have Sex with Men and Women - IDUs (MSM&W-IDU)
Other IDUs	-->	Men Who Have Sex with Women - IDUs (MSW-IDU)
	-->	Women Who Have Sex with Men - IDUs (WSM-IDU)
	-->	Women Who Have Sex with Men and Women - IDUs (WSM&W-IDU)
	-->	Women Who Have Sex with Women - IDUs (WSW-IDU)
Other Adults	-->	Men Who Have Sex with Women (MSW)
	-->	Women Who Have Sex with Women (WSW)
	-->	Women Who Have Sex with Men and Women (WSM&W)
	-->	Women Who Have Sex with Men (WSM)

The 1992 Consensus report did provide population estimates for traditional risk groups by race/ethnicity. These estimates are shown in the following table:

Population Estimates for Gay/Bisexual Men and Injection Drug Users by Race/Ethnicity, 1993 Consensus Report

Risk Group	African American	Asian/Pac. Islander	Latino/ Hispanic	Native American	White
Gay/Bisexual Men					
Non-IDUs	5,506	5,792	7,802	322	35,578
IDUs	300	316	426	18	1,941
Sub-Total	5,806	6,107	8,228	340	37,519
IDUs					
Heterosexual Men	2,961	472	977	77	3,979
Women	1,568	250	517	41	2,106
Sub-Total	4,529	722	1,494	118	6,085
Total	10,335	6,829	9,722	458	43,604

The 1993 Consensus Report risk group population estimates were based on a composite of distributions from several studies and reports. The composite estimate for gay and bisexual men used the following sources: 1) reported AIDS cases in 1992; 2) a random digit-dial survey of gay and bisexual men conducted by Communications Technologies (1990); 3) the racial and ethnic distributions from Young Men's Survey (1992/93), 4) the unlinked seroprevalence survey at a STD Clinic (City Clinic 1991; and 5) the 1990 Census.

Similarly, to estimate the racial/ethnic distribution of IDUs, the consensus report used a second composite from the following sources: 1) reported AIDS cases among IDUs in 1992; 2) population-based household surveys of African Americans (Polaris Research & Development, 1989), Latinos (Fairbank, Bregman and Maullin, 1989), Filipinos (The Asian American Health Forum/Filipino Task Force on AIDS, 1990), Chinese (Asian American Recovery Services, 1990), Japanese (Asian American Recovery Services, 1990), and Southeast Asians (Center for Southeast Asian Refugee Resettlement,

1991); 3) unduplicated counts of clients in drug treatment (Community Substance Abuse Services, SFDPH, 1990-91); 4) unlinked HIV seroprevalence surveys at methadone clinics in San Francisco (1989-92); 5) street-based surveys of IDUs (Urban Health Study, 1991-92); and 6) The 1990 census.

From these composite reports, we use the following population estimates for Gay and Bisexual men: 55,000 non-IDUs and 3,000 IDUs. For non-gay IDUs, we use the following population estimates: 8,500 heterosexual men, and 4,500 women.

Estimates of the total number of other adults and adolescents (women and heterosexual men) are calculated by subtracting the population size estimates from Gay/ and Bisexual Men and IDUs from the remaining number of adults and adolescents in San Francisco. These calculations appear in the table below:

Population Estimates for Other Adults and Adolescents by Race/Ethnicity, 1993 Consensus Report

Risk Group	African American	Asian/Pac. Islander	Latino/ Hispanic	Native American	White
Remaining Adult Population in SF	62,661	176,676	85,744	2,287	311,525
Gay/Bisexual Men	- 5,806	- 6,107	- 8,228	- 340	- 37,519
IDUs	- 4,529	- 722	- 1,494	- 118	- 6,085
Other Adults	52,326	169,847	76,022	1,829	267,921

No reports are available that estimate the number of Lesbian and Bisexual Women. Therefore we used a widely circulated, but unsubstantiated estimate that 10% of the adult female population has sex with women, or approximately 31,500. This plan uses this estimate.

These population estimates were used as a basis to re-configure the risk groups to the approved transmission groups. Transmission groups can be collapsed to yield the original "risk" group. For example, to obtain population estimates of non-IDU Gay and Bisexual men, it is necessary to combine the men MSM and MSM&W groups.

Assumptions

Since there are no adequate estimates of "Risk" by age or age-group, this methodology assumes a standard age-structure. These estimates uses the City-Wide Age distribution from Census Data as the standard. Therefore, the same age-group percentages are used for all transmission categories. The City-Wide Age-group distribution is shown below:

Age-Group (Years)	Female	Male
	Age Group Distribution	
13-26	21.0 %	21.5 %
27-29	7.5 %	8.0 %
30+	71.5 %	70.5 %
Total	100.0 %	100.0 %

The following assumptions were used to obtain the size of bisexual populations (MSM&W and WSM&W): From the Young Men's Survey, 25% of MSMs had sex with a women during the previous 6 months. Therefore, we assume the population sizes of MSM&W and MSM&W-IDU to be a quarter of the MSM and MSM-IDU populations. From the 1992 Women's Survey, 52% of WSW also had sex with a man during the previous 3 years. Therefore, we assume that the 52% of WSW as WSM&W. Also from the 1992 Women's Survey, among WSW, 3.8% had injected drugs during the previous 3 years. Therefore we estimate that 3.8% of WSW and WSM&W were injection drug users. Unfortunately, there are no San Francisco studies that show the number of heterosexual men or women who have sex with a same sex partner.

HIV Seroprevalence Estimates

In the Consensus Report, the total number of HIV infections among adults and adolescents 13 years and older is 27,538 (excluding unknown race). This same number is used for these seroprevalence estimates. Seroprevalence estimates for transmission categories where the population size is less than 500 should be used with caution, since the estimate may be unstable. Seroprevalence estimates for transmission categories where the population size is less than 100 are not reported directly, but are combined with another appropriate transmission category.

Summary Estimate of HIV Infection in San Francisco

by Transmission Category

	Estimated Pop. Size	% of SF Population	Number HIV Infected	% HIV Infected	% of Total SF HIV Distribution
Overall Total:	**638,893**	**100.00%**	**27,539**	**4.31%**	**100.00%**
Transmission Groups:					
Women who Have. . .					
. . .Sex with Women	14,550	2.28%	12	0.08%	0.04%
. . .Sex with Women - IDU	575	0.09%	25	4.35%	0.09%
. . .Sex with Men and Women	15,750	2.47%	96	0.61%	0.35%
. . .Sex with Men and Women - IDU	625	0.10%	75	12.00%	0.27%
. . .Sex with Men	285,049	44.62%	529	0.19%	1.92%
. . .Sex with Men - IDU	3,300	0.52%	401	12.15%	1.46%
Sub-Total:	**319,849**	**50.06%**	**1,138**	**0.36%**	**4.13%**
Men who Have. . .					
. . .Sex with Women	252,544	39.53%	236	0.09%	0.86%
. . .Sex with Women - IDU	8,500	1.33%	1,187	13.96%	4.31%
. . .Sex with Men and Women	13,750	2.15%	4,599	33.45%	16.70%
. . .Sex with Men and Women - IDU	750	0.12%	364	48.53%	1.32%
. . .Sex with Men	41,250	6.46%	18,559	44.99%	67.39%
. . .Sex with Men - IDU	2,250	0.35%	1,456	64.71%	5.29%
Sub-Total:	**319,044**	**49.94%**	**26,401**	**8.28%**	**95.87%**

NOTE: The sum of all categories may not add to the total, due to rounding.

* Population size for this group is less than 500. Estimated prevalence should be interpreted with caution.

† Includes population estimates from other categories. Estimated prevalence should be interpreted with caution.

Estimates of HIV Infection Among 13-26 Year-olds

by Transmission Category

	Estimated Pop. Size	% of SF Population	Number HIV Infected	% HIV Infected	% of Total SF HIV Distribution
Overall Total:	**135,125**	**21.15%**	**4,703**	**3.48%**	**17.08%**
Transmission Groups:					
Women who Have. . .					
. . .Sex with Women	3,056	0.50%	2	0.07%	0.01%
*. . .Sex with Women - IDU **	*121*	*0.00%*	*4*	*3.31%*	*0.01%*
. . .Sex with Men and Women	3,308	0.50%	16	0.48%	0.06%
*. . .Sex with Men and Women - IDU **	*131*	*0.00%*	*13*	*9.90%*	*0.05%*
. . .Sex with Men	59,860	9.40%	90	0.15%	0.33%
. . .Sex with Men - IDU	693	0.10%	68	9.81%	0.25%
Sub-Total:	**67,169**	**10.50%**	**193**	**0.29%**	**0.70%**
Men who Have. . .					
. . .Sex with Women	54,297	8.50%	57	0.11%	0.21%
. . .Sex with Women - IDU	1,811	0.30%	142	7.84%	0.52%
. . .Sex with Men and Women	2,929	0.50%	800	27.32%	2.90%
*. . .Sex with Men and Women - IDU **	*160*	*0.00%*	*62*	*38.75%*	*0.23%*
. . .Sex with Men	8,786	1.40%	3,202	36.44%	11.63%
*. . .Sex with Men - IDU **	*479*	*0.10%*	*247*	*51.57%*	*0.90%*
Sub-Total:	**68,462**	**10.70%**	**4,510**	**6.64%**	**16.38%**

NOTE: The sum of all categories may not add to the total, due to rounding.

* Population size for this group is less than 500. Estimated prevalence should be interpreted with caution.

† Includes population estimates from other categories. Estimated prevalence should be interpreted with caution.

Estimates of HIV Infection Among 27+ Year-olds

by Transmission Category

	Estimated Pop. Size	% of SF Population	Number HIV Infected	% HIV Infected	% of Total SF HIV Distribution
Overall Total:	**503,768**	**78.85%**	**23,226**	**4.61%**	**84.34%**
Transmission Groups:					
Women who Have. . .					
. . .Sex with Women	11,495	1.80%	11	0.10%	0.04%
*. . .Sex with Women - IDU **	*454*	*0.07%*	*21*	*4.62%*	*0.08%*
. . .Sex with Men and Women	12,443	1.95%	80	0.64%	0.29%
*. . .Sex with Men and Women - IDU **	*494*	*0.08%*	*62*	*12.56%*	*0.23%*
. . .Sex with Men	225,189	35.25%	439	0.19%	1.59%
. . .Sex with Men - IDU	2,607	0.41%	333	12.77%	1.21%
Sub-Total:	**252,681**	**39.55%**	**946**	**0.37%**	**3.44%**
Men who Have. . .					
. . .Sex with Women	198,752	31.11%	182	0.09%	0.66%
. . .Sex with Women - IDU	6,690	1.05%	1,045	15.62%	3.79%
. . .Sex with Men and Women	10,821	1.69%	3,909	36.12%	14.19%
*. . .Sex with Men and Women - IDU **	*590*	*0.09%*	*302*	*51.19%*	*1.10%*
. . .Sex with Men	32,464	5.08%	15,634	48.16%	56.77%
. . .Sex with Men - IDU	1771	0.28%	1208	68.22%	4.39%
Sub-Total:	**251,088**	**39.30%**	**22,280**	**8.87%**	**80.90%**

NOTE: The sum of all categories may not add to the total, due to rounding.

* Population size for this group is less than 500. Estimated prevalence should be interpreted with caution.

† Includes population estimates from other categories. Estimated prevalence should be interpreted with caution.

Estimates of HIV Infection Among African Americans (Non-Hispanic)

by Transmission Category

	Estimated Pop. Size	% of SF Population	Number HIV Infected	% HIV Infected	% of Total SF HIV Distribution
Overall Total:	**62,658**	**9.81%**	**4,349**	**6.94%**	**15.79%**
Transmission Groups:					
Women who Have. . .					
. . .Sex with Women	1,449	0.23%	3	0.21%	0.01%
*. . .Sex with Women - IDU **	*199*	*0.03%*	*15*	*7.53%*	*0.05%*
. . .Sex with Men and Women	1,568	0.25%	21	1.34%	0.08%
*. . .Sex with Men and Women - IDU **	*217*	*0.03%*	*44*	*20.26%*	*0.16%*
. . .Sex with Men	27,258	4.27%	115	0.42%	0.42%
. . .Sex with Men - IDU	1,152	0.18%	232	20.15%	0.84%
Sub-Total:	**31,843**	**4.98%**	**430**	**1.35%**	**1.56%**
Men who Have. . .					
. . .Sex with Women	22,051	3.45%	44	0.20%	0.16%
. . .Sex with Women - IDU	2,961	0.46%	637	21.51%	2.31%
. . .Sex with Men and Women	1,376	0.22%	606	44.04%	2.20%
. . .Sex with Men and Women - IDU	*Population estimate under 100. Combined with Sex with Men - IDU.*				
. . .Sex with Men	4,130	0.65%	2,422	58.64%	8.79%
*. . .Sex with Men - IDU * †*	*297*	*0.05%*	*210*	*70.70%*	*0.76%*
Sub-Total:	**30,816**	**4.82%**	**3,919**	**12.72%**	**14.23%**

NOTE: The sum of all categories may not add to the total, due to rounding.

* Population size for this group is less than 500. Estimated prevalence should be interpreted with caution.

† Includes population estimates from other categories. Estimated prevalence should be interpreted with caution.

Estimates of HIV Infection Among Asian / Pacific Islanders (Non-Hispanic)

by Transmission Category

	Estimated Pop. Size	% of SF Population	Number HIV Infected	% HIV Infected	% of Total SF HIV Distribution
Overall Total:	**176,675**	**27.65%**	**2,280**	**1.29%**	**8.28%**
Transmission Groups:					
Women who Have. . .					
. . .Sex with Women †	*4,265*	*0.67%*	*1*	*0.02%*	*0.00%*
. . .Sex with Women - IDU	*Population estimate under 100. Combined with Sex with Women.*				
. . .Sex with Men and Women	4,586	0.72%	7	0.15%	0.03%
. . .Sex with Men and Women - IDU	*Population estimate under 100. Combined with Sex with Men - IDU.*				
. . .Sex with Men	84,056	13.16%	38	0.05%	0.14%
*. . .Sex with Men - IDU * †*	*221*	*0.03%*	*6*	*2.72%*	*0.02%*
Sub-Total:	**93,128**	**14.58%**	**52**	**0.06%**	**0.19%**
Men who Have. . .					
. . .Sex with Women	76,968	12.05%	38	0.05%	0.14%
*. . .Sex with Women - IDU **	*472*	*0.07%*	*21*	*4.45%*	*0.08%*
. . .Sex with Men and Women	1,448	0.23%	405	27.98%	1.47%
. . .Sex with Men and Women - IDU	*Population estimate under 100. Combined with Sex with Men - IDU.*				
. . .Sex with Men	4,344	0.68%	1,622	37.34%	5.89%
*. . .Sex with Men - IDU * †*	*316*	*0.05%*	*142*	*44.91%*	*0.52%*
Sub-Total:	**83,548**	**13.08%**	**2,228**	**2.67%**	**8.09%**

NOTE: The sum of all categories may not add to the total, due to rounding.

* Population size for this group is less than 500. Estimated prevalence should be interpreted with caution.

† Includes population estimates from other categories. Estimated prevalence should be interpreted with caution.

Estimates of HIV Infection Among Latinos / Hispanics

by Transmission Category

	Estimated Pop. Size	% of SF Population	Number HIV Infected	% HIV Infected	% of Total SF HIV Distribution
Overall Total:	**85,744**	**13.42%**	**3,841**	**4.48%**	**13.95%**
Transmission Groups:					
Women who Have. . .					
. . .Sex with Women	1,900	0.30%	1	0.05%	0.00%
*. . .Sex with Women - IDU * †*	*157*	*0.02%*	*9*	*5.73%*	*0.03%*
. . .Sex with Men and Women	2,056	0.32%	11	0.53%	0.04%
. . .Sex with Men and Women - IDU	*Population estimate under 100. Combined with Sex with Women.*				
. . .Sex with Men	37,294	5.84%	60	0.16%	0.22%
*. . .Sex with Men - IDU **	*360*	*0.06%*	*35*	*9.73%*	*0.13%*
Sub-Total:	**41,767**	**6.54%**	**116**	**0.28%**	**0.42%**
Men who Have. . .					
. . .Sex with Women	34,774	5.44%	33	0.09%	0.12%
. . .Sex with Women - IDU	997	0.15%	103	10.55%	0.37%
. . .Sex with Men and Women	1,950	0.31%	671	34.40%	2.44%
*. . .Sex with Men and Women - IDU **	*106*	*0.02%*	*47*	*44.18%*	*0.17%*
. . .Sex with Men	5,852	0.92%	2,684	45.87%	9.75%
*. . .Sex with Men - IDU **	*319*	*0.05%*	*187*	*58.59%*	*0.68%*
Sub-Total:	**43,978**	**6.88%**	**3,725**	**8.47%**	**13.53%**

NOTE: The sum of all categories may not add to the total, due to rounding.

* Population size for this group is less than 500. Estimated prevalence should be interpreted with caution.

† Includes population estimates from other categories. Estimated prevalence should be interpreted with caution.

Estimates of HIV Infection Among Native Americans (Non-Hispanic)

by Transmission Category

	Estimated Pop. Size	% of SF Population	Number HIV Infected	% HIV Infected	% of Total SF HIV Distribution
Overall Total:	**2,287**	**0.36%**	**190**	**8.31%**	**0.69%**
Transmission Groups:					
Women who Have. . .					
*. . .Sex with Women * †*	*114*	*0.02%*	*1*	*0.88%*	*0.00%*
. . .Sex with Women - IDU	*Population estimate under 100. Combined with Sex with Women.*				
. . .Sex with Men and Women	*Population estimate under 100. Combined with Sex with Women.*				
. . .Sex with Men and Women - IDU	*Population estimate under 100. Combined with Sex with Women.*				
. . .Sex with Men †	*982*	*0.15%*	*5*	*0.51%*	*0.02%*
. . .Sex with Men - IDU	*Population estimate under 100. Combined with Sex with Men.*				
Sub-Total:	**1,097**	**0.17%**	**6**	**0.55%**	**0.02%**
Men who Have. . .					
. . .Sex with Women †	*851*	*0.13%*	*12*	*1.41%*	*0.04%*
. . .Sex with Women - IDU	*Population estimate under 100. Combined with Sex with Women.*				
. . .Sex with Men and Women	*Population estimate under 100. Combined with Sex with Men.*				
. . .Sex with Men and Women - IDU	*Population estimate under 100. Combined with Sex with Men.*				
*. . .Sex with Men * †*	*339*	*0.05%*	*172*	*50.70%*	*0.62%*
. . .Sex with Men - IDU	*Population estimate under 100. Combined with Sex with Men.*				
Sub-Total:	**1,190**	**0.19%**	**184**	**15.46%**	**0.69%**

NOTE: The sum of all categories may not add to the total, due to rounding.

* Population size for this group is less than 500. Estimated prevalence should be interpreted with caution.

† Includes population estimates from other categories. Estimated prevalence should be interpreted with caution.

Estimates of HIV Infection Among Whites (Non-Hispanic)

by Transmission Category

	Estimated Pop. Size	% of SF Population	Number HIV Infected	% HIV Infected	% of Total SF HIV Distribution
Overall Total:	**311,525**	**48.76%**	**16,882**	**5.42%**	**61.30%**
Transmission Groups:					
Women who Have. . .					
. . .Sex with Women	6,915	1.08%	8	0.12%	0.03%
*. . .Sex with Women - IDU **	*273*	*0.04%*	*8*	*2.93%*	*0.03%*
. . .Sex with Men and Women	7,486	1.17%	56	0.75%	0.20%
*. . .Sex with Men and Women - IDU **	*297*	*0.05%*	*24*	*8.08%*	*0.09%*
. . .Sex with Men	135,508	21.21%	312	0.23%	1.13%
. . .Sex with Men - IDU	1,535	0.24%	126	8.21%	0.46%
Sub-Total:	**152,015**	**23.79%**	**534**	**0.35%**	**1.94%**
Men who Have. . .					
. . .Sex with Women	118,013	18.47%	120	0.10%	0.44%
. . .Sex with Women - IDU	3,979	0.62%	418	10.51%	1.52%
. . .Sex with Men and Women	8,894	1.39%	2,917	32.80%	10.59%
*. . .Sex with Men and Women - IDU **	*485*	*0.08%*	*245*	*50.52%*	*0.89%*
. . .Sex with Men	26,683	4.18%	11,670	43.74%	42.38%
. . .Sex with Men - IDU	1,456	0.23%	978	67.17%	3.55%
Sub-Total:	**159,510**	**24.97%**	**16,348**	**10.25%**	**59.36%**

NOTE: The sum of all categories may not add to the total, due to rounding.

* Population size for this group is less than 500. Estimated prevalence should be interpreted with caution.

† Includes population estimates from other categories. Estimated prevalence should be interpreted with caution.

PREVALENCE AND INCIDENCE DATA
(Published Studies & Formal Reports)

Introduction

San Francisco is fortunate to be home to a number of research institutions which have conducted a considerable number of studies focused on the HIV/AIDS epidemic. Both the University of California and the San Francisco Department of Public Health AIDS Office have conducted seroprevalence studies and surveys to examine where the epidemic has been, where it is currently, and where it is going.

This section is comprised of prevalence and incidence data from both formal studies where patients are recruited for participation and sentinel serosurveys of populations who are considered to be indicators of HIV infection. While most of the formal studies used here have been published, we have included some studies that are unpublished or have been submitted for publication. We have received permission from the authors to publish the results of all unpublished and in press data. Additionally, many of the studies, reports and serosurveys from the San Francisco Department of Public Health were used to complete this prevalence and incidence summary.

Prevalence is defined as the total number of people alive and infected with HIV in a pre-defined population divided by the total size of the population. Incidence is defined as the number of new infections for a given time period (usually one year) divided by the number of people in the population not infected at the beginning of the period and considered to be at risk for infection.

If it were possible to know the HIV status of each resident of San Francisco at all times, it might be possible to know the true incidence rate. Since this is not a realistic objective and even the size and membership of the population is constantly changing over time, it is necessary to estimate both prevalence and incidence rates. Prevalence rates are estimated for a certain group of people who share risk behaviors with other members of their group.

The San Francisco HIV Prevention Planning Council decided to review and organize the existing literature based upon the primary routes of HIV transmission: namely sexual behavior and injection drug use. Combining the four sexual behavior categories with the presence or absence of injection drug use provides the eight transmission categories shown below. Unfortunately, most published studies and AIDS office reports did not look at bisexual women and men separately.

HPPC Transmission Categories

1. Women who have sex with women (includes lesbian and bisexual women)
2. Women who have sex with women and inject drugs (includes lesbian and bisexual women)
3. Women who have sex with men
4. Women who have sex with men and inject drugs
5. Men who have sex with women
6. Men who have sex with women and inject drugs
7. Men who have sex with men (includes gay and bisexual men)
8. Men who have sex with men and inject drugs (includes gay and bisexual men)

In addition, data on youth, homeless adults and incarcerated adults was analyzed separately.

Study Selection Methodology

In looking at all of the seroprevalence studies available, we tried to limit our focus to studies conducted with residents of San Francisco only. Additionally, because of the changing nature of the epidemic and those populations being hit hardest, we tried to examine studies with samples taken in 1989 or later whenever possible. When we had to take exception to these guidelines, it is noted within the text.

HIV Prevalence and Incidence Published Studies

1. HIV Seroconversion in Intravenous Drug Users in San Francisco, 1985-1990.
Moss AR, Vranizan K, Gorter R, Bacchetti P, Watters J, Osmond D.
AIDS 1994, 8:223-231.

2. Trends in Risk Behavior and HIV Seroprevalence in Heterosexual Injection Drug Users in San Francisco, 1986-1992.
Watters JK.
In Press: Journal of Acquired Immune Deficiency Syndromes.

3. HIV Infection Among Female Injection Drug Users Recruited in Community Settings.
Watters JK, Estilo MJ, Dral AH, Lorvick JJ.
Not Yet Published.

4. Seroprevalence of HIV and Risk Behaviors Among Young Homosexual and Bisexual Men. The San Francisco/Berkeley Young Men's Survey.
Lemp GF, Hirozawa AM, Givertz D, Giuliano N, Anderson L, Linegren ML, Janssen RS, Katz M.
JAMA, 1994, 272(6):449-454.

5. Human Immunodeficiency Virus Infection in Homosexual/Bisexual Men, Ages 18-29: The San Francisco Young Men's Health Study.
Osmond DH, Page K, Wiley J, Garrett K, Sheppard HW, Moss AR, Schrager L.
Unpublished Results.

6. Risk for AIDS in Multiethnic Neighborhoods in San Francisco, California. The Population-Based AMEN Study.
Fullilove MT, Wiley J, Fullilove RE, Golden E, Catania J, Peterson J, Garrett K, Siegel D, Marin B, Kegeles S, Coates T, Hulley S.
Western Journal of Medicine, 1992, 157:32-40.

7. Comparison of Voluntary and Blinded Human Immunodeficiency Virus Type 1 (HIV-1) Seroprevalence Surveys in a High Prevalence Sexually Transmitted Disease Clinic Population.
Schwarcz SK, Bolan GA, Kellogg TA, Kohn R, Lemp GF.
American Journal of Epidemiology, 1993, 137(6):600-608.

8. HIV Infection and Risk Behaviors Among Heterosexuals in Alcohol Treatment Programs.
Avins AL, Woods WJ, Lindan CP, Hudes ES, Clark W, Hulley SB.
JAMA, 1994, 271(7):515-518.

9. HIV and Tuberculosis Infection in San Francisco's Homeless Adults. Prevalence and Risk Factors in a Representative Sample.
Zolopa AR, Hahn JA, Gorter R, Miranda J, Wlodarczyk D, Peterson J, Pilot L, Moss AR.
JAMA, 1994, 272(6):455-461.

10. Are Bisexually Identified Men in San Francisco a Common Vector for Spreading HIV Infection to Women?
Ekstrand ML, Coates TJ, Guydish JR, Hauk WH, Collette L, Hulley SB.
American Journal of Public Health, 1994, 84(6):915-919.

11. Epidemiology of Reported Cases of AIDS in Lesbians, United States 1980-1989.
Chu SY, Buehler JW, Fleming PL, Berkelman RL. 80:1380-1.

12. HIV Infection Among Female Injection Drug Users (IDUs) In The San Francisco Bay Area, California, 1989-1991.
Reardon J, Wilson MJ, Lemp GF, Gaudino JA, Snyder D, Elcock M, Nguyen S.
Paper presented at the VIII International Conference on AIDS/III STD World Congress Amsterdam, The Netherlands, 1992.

13. Drug Injectors and HIV-1 Infection in the San Francisco Bay Area. VIII.
Watters JK, Cheng Y-T, Blughenthal R, Carlson JR, Lorvick JJ.
International Conference on AIDS. Amsterdam, The Netherlands, 1992.

14. Seroprevalence of HIV-Type 1 in a Northern California Health Plan Population: An Unlinked Survey.
Wiatt RA, Cpell FJ, Ascher MS.
AJPH, April 1992, 82(4):564-567.

15. San Francisco Men's Health Study.
Unpublished Results.

16. HIV Antibody Seroprevalence Among Prisoners Entering the California Correctional System.
Singleton JA, Perkins CI, Trachtenberg AI, Hughes MJ, Kizer KW, Ascher MS.
West J Med 1990; 153:394-399.

Reports and Surveys Issued or Commissioned by the Seroepidemiology and Surveillance Branch, AIDS Office, San Francisco Dept. of Public Health

17. Projections of the AIDS Epidemic in San Francisco: 1994-1997, February 15, 1994.

18. HIV Seroprevalence and Risk Behaviors Among Lesbians and Bisexual Women: The 1993 San Francisco/Berkeley Women's Survey, October 19, 1993.

19. HIV Seroprevalence Report, September, 1993.

20. Estimates of the Number of Persons Infected With HIV in San Francisco by Race/Ethnicity, June 28, 1993.

21. HIV-1 Seroprevalence and Risk Behaviors Among Young Men Who Have Sex With Men, San Francisco/Berkeley, 1992-1993, May 1993.

22. Youth and HIV Disease in San Francisco, May 1993.

23. HIV Incidence and Prevalence in San Francisco in 1992: Summary Report From an HIV Consensus Meeting. February 12, 1992.

24. AIDS Surveillance Report, AIDS Cases Reported through May, 1994.

PREVALENCE AND INCIDENCE STUDIES FOR ADULTS

TRANSMISSION GROUP	PREVALENCE / INCIDENCE RESULTS	RACIAL/ETHNIC GROUPS MOST AT RISK	KEY BEHAVIORAL FACTORS FOR HIV INFECTION
Women who have.....			
sex w/ women (includes bisexual women)	**0.45% (1/445)** -- 1993 SFDPH HIV Seroprevalence and Risk Behavior Survey of Lesbian & Bisexual Women.[18]	Insufficient data to analyze by race/ethnicity.	Having sex with person at risk for HIV infection (gay/bisexual man or IDU).
sex w/ women -- IDU (includes bisexual women)	**7.7% (4/52)** -- 1993 SFDPH HIV Seroprevalence & Risk Behavior Survey of Lesbian & Bisexual Women.[18] **10% (2/21)** -- 1992 Methadone TX.[19]	AIDS Office survey found that African American women had a trend towards higher seroprevalence.	Needle sharing or sex with person at risk for HIV infection (gay/bisexual man or IDU).
sex w/ men	**0.4% (9/2,509)** -- 1991 Neonatal Survey.[19] **0.2% (1/623)** -- 1988-89 AMEN AIDS in Multiethnic Neighborhoods.[6] **3.6% (5/138)** -- 1990-91 Non-IDUs in alcohol TX programs (Andrew Avins).[8] **2.8% (4/143)** -- 1990-92 Drug Free TX Program[19] **0.6% (4/668)** -- 1992 STD Clinic (City Clinic) Blinded Seroprevalence Survey (women w/ no other risk factor)[19] **3.8% (1/26)** -- 1992 STD Clinic (City Clinic) Blinded Seroprevalence Survey (women w/ at risk partner)[19]	Insufficient data to analyze by race/ethnicity.	Unprotected heterosexual sex. According to the alcohol treatment program study, Non-IDU substance users reported low condom use and having sex with a partner who was an IDU. Sex with partner at risk for infection.

PREVALENCE AND INCIDENCE STUDIES FOR ADULTS

TRANSMISSION GROUP	PREVALENCE / INCIDENCE RESULTS	RACIAL/ETHNIC GROUPS MOST AT RISK	KEY BEHAVIORAL FACTORS FOR HIV INFECTION
Women who have.....			
sex w/ men -- IDU	**6.0% (5/83)** -- 1990-91 IDUs in alcohol TX programs.[8] **6.0% (26/432)** --1992 Methadone TX Programs.[19] **11.4% (46/403)** -- 1991-92 Street Based sample of female IDUs (Urban Health Study).[3] **7.0% (3/43)** -- 1992 STD Clinic (City Clinic) Blinded Seroprevalence.[19] **2.1% incidence rate per year** -- 1985-1990 seroconversion in IDUs in San Francisco.[1]	Street Based study of female IDUs found that African American women were 4.5 times more likely and Latinas were 3.9 times more likely than White women to be infected with HIV. The 1985-1990 Seroconversion article found that African-Americans were 3.4 times more likely to seroconvert than their White / Other counterparts.	Among female IDUs, having unprotected sex with men is a consistent risk factor for infection. Crack and cocaine injection use appears to increase the risk of high risk sexual and needle sharing behaviors. The 1985-1990 seroconversion study found that currently, the strongest risk factor for HIV infection among women IDUs is number of sexual partners (perhaps in association with crack use).

TRANSMISSION GROUP	PREVALENCE / INCIDENCE RESULTS	RACIAL/ETHNIC GROUPS MOST AT RISK	KEY BEHAVIORAL FACTORS FOR HIV INFECTION
Men who have.....			
sex w/ women	**0.25% (1/399)** -- 1992 Military Recruit Survey.[19] **0.5% (2/424)** -- 1988-89 AMEN AIDS in Multiethnic Neighborhoods.[6] (men w/ no other risk factor) **5.1 % (2/39)** --1988-89 AMEN (men w/ sex partner at risk or having other risk factors i.e., multiple partners, history of STD).[6] **2.6% (10/378)** -- 1990-1991 Non-IDUs in alcohol TX programs (Andrew Avins).[8] **2.3% (36/1,574)** -- 1992 City Clinic blinded seroprevalence survey (men with no other risk factor).[19] **6.1% (4/66)** -- 1992 City Clinic blinded seroprevalence (men with at risk partner).[19]	The City Clinic blinded seroprevalence survey found that African American men had a trend towards higher seroprevalence rates.	The AMEN study found that having sex with a person at risk for HIV, having a STD in the past year and having multiple partners without condom use were risk factors for HIV infection. The alcohol treatment program study found that only 3% reported consistent condom use and many reported always combining alcohol and/or drug use with sexual activity. In addition, 26% of those without a history of injection drug use reported having sex with an IDU.

PREVALENCE AND INCIDENCE STUDIES FOR ADULTS

TRANSMISSION GROUP	PREVALENCE / INCIDENCE RESULTS	RACIAL/ETHNIC GROUPS MOST AT RISK	KEY BEHAVIORAL FACTORS FOR HIV INFECTION
Men who have.....			
sex w/ women -- IDU	6.3% (29/457) --1990-92 Drug Free TX Program.[19] 14.3% (85/593) --1991 Street Based sample of male IDUs (Urban Health Study).[13] <u>1.7% incidence rate per year</u> -- 1985-1990 seroconversion in IDUs in San Francisco. [1]	The 1985-1990 seroconversion article found that African-Americans were 3.4 times more likely to seroconvert than their white/other counterparts.	Sexual risk factors such as multiple partners and low levels of condom use are common in this population. Crack and cocaine injection use appears to increase the risk of high risk sexual and needle sharing behaviors. The 1985-1990 seroconversion article found that men who were in methadone maintenance for less than 12 lifetime months were more likely to seroconvert.

TRANSMISSION GROUP	PREVALENCE / INCIDENCE RESULTS	RACIAL/ETHNIC GROUPS MOST AT RISK	KEY BEHAVIORAL FACTORS FOR HIV INFECTION
Men who have.....			
sex w/ men	**15.4% (58/376)** -- 1992 SFYMHS.[5] **48.0% (Actual #'s N/A)** -- 1990 SFMHS Surviving Cohort. [15] **51.7% (15/29)** -- 1990-92 Drug Free TX Program.[19] **32.0% (36/113)** -- 1988-89 AMEN AIDS in Multiethnic Neighborhoods.[6] **50.7% (226/446)** -- 1992 City Clinic blinded seroprevalence survey.[19] **1% incidence rate per year** -- 1989/90 SFMHS (estimated incidence that includes IDUs. Small number of seroconversions makes confidence intervals wide.)[15] **2.7% incidence rate per year** --SFYMHS (estimated incidence, includes IDUs).[5]	In the SFYMHS, non-white men were 3 times more likely to be infected than white men. In the AMEN multi-ethnic neighborhood study, there was a trend among gay/bisexual men for African Americans (63%) to have a higher seroprevalence rate than Whites (45%), Latinos (36%) and Other (43%). The "other" category included Native Americans and Asian / Pacific Islanders (this study included IDUs in race/ethnicity analysis).	In the SFYMHS, seroprevalence is associated with number of sexual partners and number of receptive anal intercourse partners in the past year. In the AMEN study, unprotected sex with more than 4 partners, history of STD infection, and having an IDU sex partner were factors associated with HIV infection.

PREVALENCE AND INCIDENCE STUDIES FOR ADULTS

TRANSMISSION GROUP	PREVALENCE / INCIDENCE RESULTS	RACIAL/ETHNIC GROUPS MOST AT RISK	KEY BEHAVIORAL FACTORS FOR HIV INFECTION
Men who have.....			
sex w/ men -- IDU	**36.0% (16/44)** -- 1992 SFYMHS.[5] **59.0% (23/39)** -- 1988-89 AMEN AIDS in Multiethnic Neighborhoods.[6] **68.9% (82/119)** -- 1992 City Clinic blinded seroprevalence survey.[19] **1% incidence rate per year** -- 1989/90 SFMHS (estimated incidence. Includes non-IDUs and small number of seroconversions makes confidence intervals wide.)[15] **2.7% incidence rate per year** --SFYMHS (estimated incidence. Includes non-IDUs).[5]	In the AMEN multi-ethnic neighborhood study, there was a trend among gay / bisexual men for African Americans (63%) to have a higher seroprevalence rate than Whites (45%), Latinos (36%) and Other (43%). The "Other" category included Native Americans and Asian / Pacific Islanders. (This study included non-IDUs in race/ethnicity analysis). In the 1992 City Clinic Blinded Survey, there was no difference in seroprevalence by race/ethnicity.	In the SFYMHS, IDUs were 2.5 times more likely to be HIV positive than non-IDU young men.

TRANSMISSION GROUP	PREVALENCE / INCIDENCE RESULTS	RACIAL/ETHNIC GROUPS MOST AT RISK	KEY BEHAVIORAL FACTORS FOR HIV INFECTION
Women who have.....			
sex w/ women	No data available.	No data available.	No data available.
sex w/ women - IDU	No data available.	No data available.	No data available.
sex w/ men	**0.8% (5/611)** -- 1990-92 SPY data for homeless youth. There were no seropositive incarcerated females.[22] **0.4% (1/284)** 1992 STD Clinic (City Clinic) Blinded Seroprevalence Study for women < = 24 years.[19] **1.0% (9/878)** --1989-1991 STD Clinic (City Clinic) Blinded Seroprevalence study < = 24 years.[19] **0.2% (1/660)** 1991 Neonatal Survey < = 24 years.[19]	The number positive is too low to look at differences based on race/ethnicity.	No data available.
sex w/ men -- IDU	**2.8% (2/72)** -- 1990-92 SPY data for homeless youth. There were no seropositive IDUs among incarcerated youth.[22] **2.6% (1/39)** 1989-1991 City Clinic Blinded Seroprevalence study < = 24 years.[19]	The number positive is too low to look at differences based on race/ethnicity.	No data available.

PREVALENCE AND INCIDENCE STUDIES FOR YOUTH

TRANSMISSION GROUP	PREVALENCE / INCIDENCE RESULTS	RACIAL/ETHNIC GROUPS MOST AT RISK	KEY BEHAVIORAL FACTORS FOR HIV INFECTION
Men who have.....			
sex w/ women	**0.7 % (2/302)** -- 1990-92 SPY data for homeless youth.[22] **0.31% (3/971)** -- 1990-92 SPY data for incarcerated youth.[22] **0.5% (3/567)** -- 1992 STD Clinic (City Clinic) Blinded Seroprevalence < = 24 years.[19] **0.9% (15/1,621)** 1989-91 City Clinic Blinded Seroprevalence < = 24 years.[19] **0% (0/289)** -- 1992 Military Recruit.[19]	No data available.	No data available.
sex w/ women - IDU	**0 % (0/48)** -- 1990-92 SPY data for homeless youth. There were no seropositive IDUs among incarcerated youth.[22] **6.3% (3/48)** 1989-1991 City Clinic Blinded Seroprevalence < = 24 years.[19]	No data available.	No data available.

TRANSMISSION GROUP	PREVALENCE ESTIMATE RANGE	RACIAL/ETHNIC GROUPS MOST AT RISK	KEY BEHAVIORAL FACTORS FOR HIV INFECTION
Men who have..... sex w/ men	**25.6% (23/90)** -- 1990-92 SPY data for Homeless Youth.[22]	No racial/ethnic differences with SPY data were apparent.	
	10.0% (1/10) -- 1990-92 SPY data for incarcerated youth.[22]		
	7.4% (34/280) -- 1992 - 93 YMS data for all sites (17-22 years).[4]	YMS found that African Americans were 2.5 times more likely than Whites to be infected with HIV.	YMS found that young men who had 10 or more lifetime partners were 2.1 times, those with 50 or more lifetime partners were 4.5 times, and men with a history of STD infection were 6.4 times more likely to be infected with HIV.
	4.8 % (4/84) -- 1992 SFYMHS (18-23 years).[5]		
	10.7 % (16/149) -- 1992 SFYMHS (24-26 years).[5]	SFYMHS found that non-White populations were 3 times more likely than Whites to be infected w/ HIV.	SFYMHS showed that seroprevalence is associated with number of sexual partners and number of receptive anal intercourse partners in the past year.
	26.9 (60/223) - -1989-1991 City Clinic Blinded Seroprevalence < = 24 years.[19]		
	4% incidence rate per year -- 1992-93 YMS (estimated incidence. Includes IDUs.)[4]		
	1.2% incidence rate per year -- 1992 SFYMHS (18-23 years.) Estimated incidence. Includes IDUs.[5]		
	1.8% incidence rate per year -- 1992 SFYMHS (24-26 years.) Estimated incidence. Includes IDUs.[5]		

PREVALENCE AND INCIDENCE STUDIES FOR YOUTH

TRANSMISSION GROUP	PREVALENCE ESTIMATE RANGE	RACIAL/ETHNIC GROUPS MOST AT RISK	KEY BEHAVIORAL FACTORS FOR HIV INFECTION
Men who have.....			
sex w/ men -- IDU	**50% (21/42)** -- 1990-92 SPY Data for Homeless Youth ; there were no seropositive IDUs for incarcerated youth.[22] **20% (14/70)** -- 1992-93 YMS.[4] **36% (16/44)** -- 1992 SFYMHS All sites (17-22 years).[5] **34.4% (11/34)** -- 1989-1991 STD Clinic (City Clinic) Blinded Seroprevalence < = 24 years.[19] **4% incidence rate per year** -- 1992-93 YMS. (Estimated Incidence. Includes non-IDUs.)[4] **1.2% incidence rate per year** -- 1992 SFYMHS (18-23 years.) (Estimated incidence. Includes non-IDUs.)[5] **1.8% incidence rate per year** -- 1992 SFYMHS (24-26 years.) (Estimated incidence. Includes non-IDUs.)[5]	No racial/ethnic differences with SPY data were apparent. YMS found that African Americans were 2.5 times more likely than Whites to be infected with HIV. SFYMHS found that non-White populations were 3 times more likely than Whites to be infected w/ HIV.	YMS found that young men who had 10 or more lifetime partners were 2.1 times, those with 50 or more lifetime partners were 4.5 times, and men with a history of STD infection were 6.4 times more likely to be infected with HIV. SFYMHS showed that seroprevalence is associated with number of sexual partners and number of receptive anal intercourse partners in the past year.

POPULATION GROUP	PREVALENCE ESTIMATE RANGE	RACIAL/ETHNIC GROUPS MOST AT RISK	KEY BEHAVIORAL FACTORS FOR HIV INFECTION
Homeless - Female Adults	3.6 (8/222) 1990 - 92 representative sample of homeless recruited from shelters and food lines. (Andrew Zolopa)[9] Heterosexual: **3.4%** Bisexual: **0.0%** Lesbian: **7.1%** IDU - Current: **15.8%** (3/19) IDU - Past: **7.0%** No IDU ever: **0.7%**	African Americans: **4.8%** Hispanic / Latino: **0.0%** White: **2.2%**	For women, 7 of the 8 HIV positive women had a history of IDU (including current use).
Homeless - Male Adults	**10.0%** - 1990 - 92 representative sample of homeless recruited from shelters and food lines. (Andrew Zolopa)[9] Heterosexual: **4.2%** Bisexual: **15.3%** Gay: **45.1%** IDU - Current: **19.7%** IDU - Past: **11.9%** No IDU ever: **6.1%**	African American: **11.3%** Hispanic / Latino: **6.2%** White: **8.4%**	For men, being gay, bisexual, African American, selling sex, injecting drugs, or injecting in shooting gallery were all independent and significant risk factors for HIV infection.

PREVALENCE AND INCIDENCE STUDIES FOR OTHER POPULATIONS

POPULATION GROUP	PREVALENCE ESTIMATE RANGE	RACIAL/ETHNIC GROUPS MOST AT RISK	KEY BEHAVIORAL FACTORS FOR HIV INFECTION
Sex Workers - Female Adults	13.9 % -- 1990 - 91 Project Aware.[23] Crack users: 18% IDUs: 12% Crack & IDU: 14%	6 of the 10 seropositive women were African American (70% of the total sample was African-American).	
Incarcerated Female Adults	3.1% - Overall (All Correctional Systems in California) -- 1988 seroprevalence study (Jim Singleton).[16]		Authors speculate that higher seroprevalence among prisoners arrested in San Francisco is a reflection of higher seroprevalence among IDUs in San Francisco, compared to the rest of California.
Incarcerated Male Adults	2.5% - Overall (All Correctional Systems in California) -- 1988 seroprevalence study (Jim Singleton).[16] 5.3% - Men arrested in San Francisco.		Authors speculate that higher seroprevalence among prisoners arrested in San Francisco is a reflection of higher seroprevalence among IDUs in San Francisco, compared to the rest of California.

WOMEN WHO HAVE SEX WITH WOMEN

There have been very few documented cases of female to female sexual transmission of HIV in the United States. While part of this observation may be due to mis classification by CDC case classification criteria, which does not acknowledge female to female transmission, it does not disqualify the conclusion that female to female transmission is rare. It is clear from AIDS case data and the few HIV seroprevalence studies that have specifically identified lesbians, that the primary risk behavior for infection in women who only have sex with other women has been injection drug use. While there have been 13 documented cases of AIDS in lesbian and bisexual IDUs in San Francisco as of May 31, 1994, there have been no documented cases of women to women sexual transmission (24).

In one of the few studies of HIV seroprevalence and risk behaviors in lesbian and bisexual women, Lemp, et al. found an overall seroprevalence of 1.2% (6/498) in lesbian and bisexual women who frequented public venues in San Francisco and Berkeley (18). This sample of women is possibly at higher risk for HIV infection due to the sampling technique used (a convenience sample much like the Young Men's Study (21)). Out of the 90 women who reported *only* having sex with other women since 1978, none were infected. All of the cases of infection involved injection drug use, a history of sex with a gay/bisexual man or both. While these figures are not large enough to identify a pattern by age or race, 0.34% (1/297) of the women infected were between 20 and 29, 2.68% (4/149) were between 30 and 39 and 3% (1/33) were 40 and over. While 0.74% (2/269) were White, 3.57% (3/84) were African American, 1.35% (1/74) were Latina and 0% were Asian/Pacific Islander (0/59) or Native American (0/9).

Injection Drug Use

In sharp contrast to the low seroprevalence found in non-IDU lesbian and bisexual women (1/445, 0.4%, 95%CI = 0.1-1.6), this study found that 4 out of 52 (7.7%, 95%CI = 2.1%-18.5%) IDU women were infected. In univariate analysis, IDU women in this sample were 18.5 times more likely (95%CI = 3.3-104) to be infected with HIV than non-IDU women. Nationally, Chu, et al. reported that of 79 reported cases of AIDS in lesbians through September 30, 1989, 75 were IDUs and 4 were the recipients of blood or blood products (11).

In a study of female IDUs entering treatment in the San Francisco Bay Area, Reardon et al. found a trend towards increased seroprevalence in lesbian and bisexual women as compared to heterosexual women (11% vs. 7%) (12).

Sexual Orientation versus Sexual Behavior

An additional difficulty arises in describing the seroprevalence in women who have sex with women because most women who self-identify as lesbians have had sex with men in the past or occasionally have sex with men. In the aforementioned study, Lemp et al. found that while 68% of the women self-identified as lesbian, only 18% had sex with only women since 1978. All of the women who were infected and self-identified as lesbian reported sex with men in the past.

Women Who Have Sex with Men and Women

Women who have sex with both men and women have an increased rate of seroprevalence as compared to women who have sex with women and women who have sex with men. Much like women who have sex with women, the primary route of transmission for this population of women is through injection drug use. Analyzing national AIDS case data for behaviorally bisexual women, Chu et al. found 103 reported cases through September 30, 1989, of whom 79% were IDUs, 16% had sex partners of increased risk or known to be infected with HIV and 4% were recipients of blood or blood products.

Locally, Lemp et al. found that over 20% of the women in his study had unprotected sex with a gay or bisexual man and were 8.2 times (95%CI = 1.5-45.7) as likely to be infected with HIV when compared to women who had not engaged in this activity.

In Summary

While lesbian and bisexual women represent a relatively small number of HIV infections and AIDS cases, their risk for infection is greatly increased by injection drug use and by sexual contact with gay or bisexual men and male injection drug users. Initial results from studies with lesbians demonstrate the need to define populations by their behaviors rather than their self-identified sexual orientation. Prevention services for this population should be focused at reducing injection drug use and increasing condom use during sex with men.

WOMEN WHO HAVE SEX WITH MEN

In the first years of the AIDS epidemic, HIV infection in women was thought to have been confined to women who were exposed through sharing of injection drug equipment. Over the last several years, there has been an additional and increasing trend of transmission of HIV to women through heterosexual contact. In San Francisco, almost 29% (147/509) of the AIDS cases among women through May 31, 1994 have occurred among women whose only exposure was reported to be through heterosexual contact (24). While this trend towards heterosexual transmission is an emerging threat, it by no means signifies that the risk for IDU women is decreasing. Quite the contrary, the total number of AIDS cases and HIV infection among women is increasing, both among IDUs and increasingly among non-IDUs who are the sexual partners of male IDUs.

Women who have sex with men who are not injection drug users and not sex partners of men at risk for HIV infection have been at very low risk of infection in San Francisco because of the low prevalence of HIV in the general population. Data from a variety of studies show the prevalence of HIV at less than one percent in this population of women (6, 7, 14, 19, 20, 23). The population based multi-ethnic study in San Francisco (AMEN) Study reported a prevalence of 0.16% (1/623) in its sample of non-IDU women from the Western Addition, Mission and Bayview/Hunter's Point (6). The California Office of AIDS reported that of 2,509 mothers of newborn infants in 1991, only 9 were HIV positive, yielding a prevalence rate of 0.36% (95%CI, 0.16-0.68) (19).

While women who are giving birth are probably not representative of women in the general population and may represent a low estimate of overall prevalence, the San Francisco Municipal STD Clinic (City Clinic) reports that for heterosexual women coming in to the clinic for first time treatment of an STD in 1992 who have no other identifiable risk factors, 0.6% (4/668, 95%CI 0.2-1.5%) were infected with HIV (19). Since subjects recruited at STD clinics are usually considered to be at a higher risk for HIV and other STDs than the general population, considered together, these two samples converge to form a picture of low seroprevalence within this population. However, given the ongoing presence of HIV in San Francisco, women's risk for HIV infection through sex with men is likely to increase.

Because of the current low prevalence of HIV infection in this population, it is difficult to observe any trends in seroprevalence that may be related to age and/or race/ethnicity. An alarming divergence from this overall picture occurs in women who are injection drug users, non-IDU substance abusers

and women who are sex partners of men at risk for HIV infection as detailed in the following text.

Injection Drug Use

Several studies have documented an HIV seroprevalence of between 6% and 12% in heterosexual women who inject drugs in San Francisco (1, 2, 3, 19). Studies which have found lower seroprevalence are usually associated with samples taken from in-treatment locations while higher seroprevalence is noted from street-based or community samples.

In a sample of female IDUs recruited from community settings in 1991-1992, Watters et al. reported an overall seroprevalence of 11.4% (46/403) (3). In multivariate analysis, five factors independently associated with HIV seroprevalence included three sexual behavior related variables, race and use of crack cocaine. Age and use of needle exchange for source of needles were not significantly associated with seroprevalence in this sample. Factors associated with higher seroprevalence included a reported history of syphilis (AOR=3.30, 95%CI = 1.36-7.99), a history of being paid for sex (AOR=3.11, 95%CI = 1.37-7.02), and being African American (AOR=5.31, 95%CI = 2.05-13.73) or Hispanic (AOR=3.74, 95%CI = 1.33-10.48). Reporting a steady partner (AOR=0.48, 95%CI = 0.24-0.94) and use of crack cocaine(AOR=0.33, 95%CI = 0.15-0.71) were associated with lower seroprevalence.

The significance of the three sexual behavior variables demonstrates that high risk sexual behavior is a principal risk factor for HIV infection within this group of IDUs. While the apparent protective effect of crack cocaine use is at first surprising, it is not from any 'magical' effect of crack or a difference in risk behaviors, but may stem from the increased likelihood of the sex partner of an injection drug using woman who smokes crack not being an IDU, and thus being at lower risk for HIV infection. In fact, women who were both IDUs and crack users reported higher number of risk behaviors than those who did not use crack and could be at higher risk for HIV infection from these behaviors.

Non-IDU Substance Users

While sharing of drug injection equipment and history of injection drug use are well established risk factors for HIV infection, there are signs that non-IDU substance using women are also at high risk for HIV infection. Avins et al (8), showed that while seroprevalence in female IDUs in an alcohol treatment program was 6%, non-IDU females had a seroprevalence of 3.6%. A similarly high infection rate of 2.8% was found among non-IDU women in

a methadone-free outpatient residential drug treatment program (19). Possible explanations for this elevated seroprevalence include similar risk taking behaviors and demographics between women who abuse alcohol and other non-IDU substances and women who are injection drug users. It is quite possible that women who are abusers of alcohol and other non-injection drugs may have male sex partners who are IDUs and are being infected through sexual contact with this person. Whatever the cause, these data point to another sub-population at risk for infection that has not been previously identified.

In Summary

The elevated HIV prevalence shown above for non-IDU women sampled from an alcohol treatment program demonstrates the incidence of heterosexual transmission of HIV in the absence of injection drug use history. Additionally, Watters' data showed that high risk sexual risk behaviors significantly increased seroprevalence among injection drug using heterosexual women.

MEN WHO HAVE SEX WITH WOMEN

In San Francisco, HIV and AIDS among men has been almost completely confined to homosexual or bisexual men and injection drug users. Together, these two groups account for 98.5% of the cumulative total of AIDS cases to date (through May 31, 1994) (24). Heterosexual men who are not injection drug users account for just 0.2% of the total number of AIDS cases in men. While not representative of the general heterosexual population, data from civilian applicants for military service for 1985-1992 (19) reveals a low prevalence rate of 0.44% (21/4733) (19).

While the estimated prevalence rate for heterosexual men with no reported risk behaviors is generally less than one percent, heterosexual men who are not injection drug users but have other risk behaviors (such as a history of STD, drug use, sex partners at risk for infection and multiple sexual partners) are manifesting an elevated seroprevalence rate.

The AMEN Study provides an ethnically diverse population based sample of White, African American and Hispanic/Latino heterosexual men from three multi-ethnic neighborhoods (6). Within this group, self-identified heterosexual men who reported no identified risk behaviors had a seroprevalence of 0.5% (2/424, 95%CI = 0.1-1.7) while heterosexual men who reported other risk behaviors (having a sex partner at risk for HIV infection, having had an STD within the past year, or having had sex with more than 4 partners without a condom) had a seroprevalence of 5.1% (2/77, 95%CI = 0.6-17.3). Heterosexual men coming into the City Clinic (the municipal STD clinic) for first time treatment of an STD who reported no other risk factors had a seroprevalence of 2.3% (36/1574, 95%CI = 1.6-3.2) while those who reported having a sex partner at risk for HIV infection had a trend toward a higher seroprevalence of 6.1% (4/66, 95%CI = 1.7-14.8). These data strongly suggest the significance of sexual transmission of HIV to men when they have female sex partners who are infected.

Injection Drug Use

HIV infection through needle sharing has been the predominant means of infection for heterosexual men in San Francisco and the United States. As of May 31, 1994 there were 826 reported AIDS cases among heterosexual IDUs in San Francisco (4.3% of the total for all men and 75% of the total for men who were not gay or bisexual). Moss et al. reported that among seronegative IDUs who returned for at least one visit during a 5 year period, incidence rates fell from 3.9% (95%CI = 2.1-5.5) in the period 8/85 to 4/87 to between 1.2% (95%CI

= 0.5-1.9) and 1.9% (95%CI = 0.8-3.0) through 1990 (1). The average HIV incidence for men in the sample for the whole period was 1.7%. In multivariate analysis, African Americans were 3.4 times more likely to seroconvert than their white counterparts.

HIV seroprevalence in heterosexual male injection drug users has been estimated between 6% and 14% in San Francisco depending on where the samples were taken. Studies which have found lower seroprevalence are usually associated with samples taken from in-treatment locations while higher seroprevalence is noted from street-based or community samples. In samples obtained primarily from community settings, Watters et al. reported an overall seroprevalence of 14.3% (85/593) for heterosexual male IDUs. Seroprevalence rates of 7.7% (20/261) and 7.4% (63/849) have been reported from an alcohol treatment program and methadone treatment centers for this group of men (8).

Non-IDU Substance Users

Heterosexual men enrolled in alcohol and drug treatment programs who are not injection drug users also show elevated seroprevalence when compared to men with no identified risk behaviors. Seroprevalence rates for non-injection drug using substance users from an alcohol treatment program and drug free outpatient treatment program were 2.6% (10/378) and 2.8% (10/360) respectively (19).

MEN WHO HAVE SEX WITH MEN

Men who have sex with other men continue to comprise the transmission group with the highest prevalence of HIV in San Francisco. Out of the 28,000 men, women and children estimated to be infected and living in San Francisco in 1992, approximately 25,000 are thought to be gay and bisexual men (23). Using an estimate of 59,000 gay and bisexual men living in the City, this works out to an overall seroprevalence of 42%. Population based estimates of HIV seroprevalence within this group vary significantly based on demographics and risk behavior; ranging from 15.4% in young (18-29) predominantly white gay/bisexual men living in the Castro area (5), to 48% among surviving members of the San Francisco Men's Health Study (SFMHS) cohort (23), to 63% in 20 to 44 year old African American gay/bisexual men living in the Mission, Western Addition and Bayview/Hunter's Point (6).

Age

The San Francisco Young Men's Health Study (SFYMHS) estimates that 29% of its sample of men who have sex with men between the ages 27 and 29 are HIV positive. It is not surprising that seroprevalence rates are high for a group of men who were sexually active in San Francisco in the early 1980's. Annual incidence rates estimated from the SFMHS data show an annual incidence of 18% per year in 1982-84, dropping to 5% per year in 1984-85 and then 2% per year in 1986-87. Many gay and bisexual men who are now in their late 20's and early 30's and were sexually active in San Francisco in the early-1980's, when seroconversion rates were still very high, are now living here with HIV infection.

What is most alarming in this data is the relatively high seroprevalence found among young gay men. In 1992, the SFYMHS estimated that 5% of gay men living in the Castro area between the ages of 18-23 and 11% between the ages of 24 to 26 were infected with HIV. These data suggest an annual incidence rate of 1.2% and 1.8% per year, respectively. This trend represents an ominous departure from the "accepted" incidence rates of approximately 1% for older gay and bisexual men in the SFMHS.

While not necessarily figures which may be generalized to the overall population of men who have sex with men, the Young Men's Survey, a convenience sample conducted by the AIDS Office in 1992, estimates a seroprevalence rate of 4% for men 17-19 and almost 12% for men 20-22 years of age. The City Clinic (the municipal STD clinic) reports that 17.4% of men between the ages of 20 and 24 screened for syphilis in 1992 were HIV-positive.

When considered together, data from these three sources paint an ominous picture of the prevalence of HIV and a high seroconversion rate in this young group of men.

Race/Ethnicity

When we examine the published data looking at seroprevalence by race/ethnicity, a number of shortcomings become apparent in the larger population based studies. Most notably, Asians, Pacific Islanders and Native Americans were not consistently identified from study to study and were usually categorized into the 'Other' category. For example, the AMEN study of HIV infection in three multiethnic neighborhoods, failed to separate Asians, Pacific Islanders and Native Americans in their analysis. Unfortunately, this study found a 43% prevalence rate in this poorly defined 'Other' group. Because of this under-classification, it is difficult to apply this very significant statistic to any particular population that makes up this 'Other' group.

While several of the studies examined showed trends toward different rates of infection among gay and bisexual men of color, most did not have a sufficiently large number of individuals in each racial/ethnic group to elucidate any differences with statistical significance. The SFYMHS is able to show that non-white young gay and bisexual men were 3.0 (AOR 95%CI = 1.6-5.7) times more likely to be seropositive based on race alone, accounting for the independent effects of injection drug use, number of receptive anal intercourse partners and first year of regular intercourse. However, because of the small number of men in each racial/ethnic minority group, measures of association could not be assessed for each group.

While the AMEN study is the only population based study with a large number of African American and Hispanic/Latino men, only 7% (8/117) of the African American and 6% (11/180) of the Hispanic/Latino men in the sample admitted to being homosexually active. Although not significant, data from this study does show a prevalence of 63% in African American men, 36% for Hispanic/Latino men and 45% for White men.

Injection Drug Use

The HIV estimates shown in Section F of this report indicate that there is a trend of an additive risk for gay and bisexual men who are also IDUs (although these estimates have less precision than the non-IDU estimates because they are based on smaller sample sizes). Across published studies, there is between a 35% and 133% increase in the seroprevalence rate for gay

and bisexual men who inject drugs compared to those who are non-injection drug users, not adjusting for age and race. The SFYMHS showed that while controlling for the effect of age, race and number of sexual partners, injection drug users were 2.5 times (AOR 95%CI = 1.1 - 5.7) more likely to be infected than their non-IDU peers.

In Summary

Nearly one out of every two gay or bisexual men in San Francisco is infected with HIV. While for men over 30, some of this prevalence can be accounted for in seroconversion which took place in the early to mid-1980's, an alarmingly high rate of seroprevalence among younger gay and bisexual men points to a resurgence of new infection with this sub-population. There also appears to be a trend towards higher rates of seroprevalence among non-white gay and bisexual men (especially African American men). Seroprevalence rates for and gay men is highest among those who also inject drugs.

Limitations of the Studies

Many of the studies we examined did not stratify by injection drug use when they examined seroprevalence by race/ethnicity. Injection drug users were mixed in with non-injection drug users for an "overall" seroprevalence breakdown by race/ethnicity. Since injection drug use alone is a risk factor for HIV infection, analysis of the prevalence associated with race without separating IDUs and non-IDUs may distort the true relationship of race as an independent effect. It is possible that the prevalence of HIV that is reportedly associated with each race is partially confounded by the effect of injection drug use.

While men who have sex with other men are historically the most studied population when it comes to HIV infection and prevention, there are still many gaps in our understanding of differences within this population. Most studies continue to group bisexual men together with homosexual men even though their risk behaviors and, hence, seroconversion rate appear to be quite different. Another example is the absence of a large population based cohort study of gay men of color who have sex with men who, from the data we do have, appear to have much higher prevalence than their white counterparts. While it is generally accepted that men of color are at higher risk for infection than whites, the complex set of conditions, characteristics and behaviors that go into creating this difference has not been well explained.

Recommendations for Future Research

Larger studies of male IDUs who have sex with men are clearly needed. Included in this sample should be a sufficient number of men to produce statistically significant seroprevalence results for each race/ethnic group. Expanded use of long-term cohort design is recommended, since it is the only true design where incidence and prevalence can be measured.

YOUTH IN SAN FRANCISCO

Youth in San Francisco are a heterogeneous group of young people who are defined by their age, ranging from approximately 13 to 26 years old. In addition to the vast difference in age for this population, youth vary significantly in their ethnicity, culture, socio-economic status, sexual orientation, sexual behaviors and gender. As a group who are just beginning to engage in behaviors that could put them at risk for HIV infection, it is imperative to reach youth with effective prevention services during this formative period.

While youth currently comprise a very small percentage of the AIDS cases in San Francisco, there are a large number of young men with AIDS 27 to 29 years old who were most likely infected in their teens. Ninety percent of youth with AIDS are men who have sex with men.

While it is clear that there is a need for seroprevalence and sexual behavior studies among youth, the studies that have been done and data collected from various point of access clinics indicate that the youth who are currently infected and those most at risk for infection are similar to their older counterparts. The San Francisco Youth and HIV Disease report estimates that out of approximately 900 HIV infected youth living in San Francisco, approximately 73% are among men having sex with men (22).

Young Women

Using 1990-92 Special Programs for Youth (SPY) data for runaway youth and 1989-91 City Clinic seroprevalence data for non-IDU young women having sex with men, the seroprevalence of HIV appears to be at or below one percent (SPY: 0.8%, 5/611; CC: 1%, 9/878) (19). Data from the 1991 and 1992 Neonatal Survey yields a seroprevalence estimate well below one percent (0.2%, 1/660 (91); 0%, 0/593 (92)). While none of these sources are generally representative of the overall population, the low seroprevalence among young heterosexual women who are not injecting drugs would appear to indicate a relatively low level of risk in the past. Among women who have sex with men and inject drugs, SPY and City Clinic data estimate a seroprevalence of approximately 2 to 3 percent (SPY: 2.8%, 2/72; CC: 2.6%, 1/39). However, due to the small sample size of theses estimates, they should be interpreted with caution.

While there is no data on HIV seroprevalence among young lesbian and bisexual women, there is no reason to believe that they are not at risk from

the same behaviors as their older counterparts; primarily injection drug use and unprotected sex with a gay/bisexual and/or injection drug using man.

Young Men

Using the SPY data for runaway youth and City Clinic seroprevalence data for non-IDU young men having sex with women, the estimated seroprevalence of HIV infection is less than one percent (SPY: 0.7%, 2/302; CC: 0.9%, 15/1,621) (19). The 1991 and 1992 Seroprevalence study of Military Recruits yields a seroprevalence of 0.3% (1/336) and 0% (0/289) respectively (19). Among men who have sex with women and inject drugs, SPY and City Clinic data yield very different estimates of seroprevalence of 0 to 6 percent (SPY: 0%, 0/48; CC: 6.3%, 3/48).

Two population based studies of men who have sex with men show an alarming seroprevalence rate among young gay/bisexual men. The Young Men's Study (YMS), found an overall seroprevalence rate of 7.4% (34/280) among young gay/bisexual men who had never injected drugs (4). These results are higher than the estimates found by the San Francisco Young Men's Health Study (SFYMHS), which showed an estimated seroprevalence of 4.8% (4/84) for men 18-23 and 10.7% for men 24-26 years old (5). While these differences are partially attributed to differences in the sampled population of young gay men, both studies found higher than expected rates of infection among their sample. Using 1990-92 SPY data for runaway youth and 1989-91 City Clinic data for gay/bisexual men under 25 show extraordinarily high rates of infection are shown (SPY: 25.6%, 23/90; CC:: 26.9%, 60/223).

The prevalence of injection drug use is a separate epidemic among young men who have sex with men. Approximately 17% (70/423) of the men in YMS and 10% (44/428) in SFYMHS reported a history of injection drug use. Not surprisingly, seroprevalence rates among young gay/bisexual men who have a history of injecting drugs were much higher than those who had did not. Within this sub-population of young men, 20% (14/70) were infected in YMS, 36% (16/44) in SFYMHS, 50% (21/42) in SPY data and 34.4% in City Clinic data.

SFYMHS revealed incidence rates of 1.2% per year for men 18-23 and 1.8% for men 24-26 while YMS data produced a shocking incidence rate of 4% per year.

Both YMS and SFYMHS provided evidence that young gay men of color are at increased risk of HIV infection. YMS data found that African American men were 2.5 times more likely to be infected with HIV while SFYMHS

found that non-white men were 3 times more likely to be infected with HIV than Whites.

HOMELESS POPULATIONS

Homeless Adults

Seroprevalence data on San Francisco's homeless population, both youth and adults, has been terribly deficient and is identified in this prevention plan as a data need for future research. To date, there has been just one population based study of HIV seroprevalence in homeless adults (9). While this was a well conducted and representative study, the large size of this population (estimated at between 11,000 to 16,000) in combination with the high levels of alcohol and drug use, the high prevalence of mental illness, and limited resources would appear to put homeless populations at an elevated risk of HIV infection and warrants further investigation.

Zolopa et al. conducted an in-depth study on the prevalence and risk factors for HIV and TB infection among homeless adults, sampling from both shelters and food lines (9). The sample in this study was found to be predominantly male (82%), mostly African American (49%) or White (37%) and to have a median age of 36 years. Surprisingly, 22% of the men and 20% of the women reported being homosexual or bisexual. Both of these rates are higher than the overall rate of 14% generally used to estimate the size of the lesbian and gay community in San Francisco.

While the prevalence rate of HIV was 8.5% in the overall population, it differed dramatically in men and women (10.0% in men and 3.6% for women). In addition, the level of TB infection (as measured by a positive reaction to PPD) was 35% in men and 27% in women.

The univariate prevalence rates of HIV based on race, sexual orientation and injection drug use history for men and women is shown in the following table.

Seroprevalence based on:	Men	Women
Race		
African American	11.3%	4.8%
Hispanic/Latino	6.2%	0.0%
White	8.4%	2.2%
Sexual Orientation		
Heterosexual	4.2%	3.4%
Bisexual	15.3%	0.0%
Gay / Lesbian	45.1%	7.1%
IDU History		
IDU - Current	19.7%	15.8%
IDU - Past	11.9%	7.0%
No IDU Ever	6.1%	0.7%

For men being gay or bisexual, African American, or injecting drugs were all independent and significant risk factors for HIV infection. For women, 7 of the 8 HIV positive women had a history of injection drug use or were current injectors.

Homeless Youth

Seroprevalence estimates of homeless youth are limited to SPY clinic based data. These data show a high rate of seroprevalence among non-injecting (25.6%) and injecting (50%) men who have sex with men. Seroprevalence rates among young women who have sex with men have been shown in SPY data to be .8% but rise to 2.8% if these young women also inject drugs. Rates among young men who have sex with women are .7%.

WOMEN WHO HAVE SEX WITH WOMEN - NON-IDU

Prevalence Estimate	95% Conf Int	Study Name
0.45% (1/445)		(1) HIV in Lesbians and Bisexual Women - 1993 (case was in women with bisexual behavior)
0 (0/31)	0.0 - 9.2	(2) City Clinic 1992 - Family of Surveys
0 (0/25)	0.0 - 11.3	(3) Drug Free Outpatient Txt. Prog. 1990-92

Race / Ethnicity Breakdown

	Af. Am.	As/PI	Hispanic	Native A	White	Other	Unknown
(1)	not stratified						
(2)	not stratified						
(3)	not stratified						

HIV Prevalence Data from Studies

WOMEN WHO HAVE SEX WITH WOMEN - IDU

Prevalence Estimate	95% Conf Int	Study Name
7.7% (4/52)		(1) HIV in Lesbians and Bisexual Women - 1993 (all cases were in women with bisexual behavior)
10% (2/21)	1.2 - 30.4	(2) Methadone Txt. Center - 1992
0 (0/36)	0.0 - 8.0	(3) Drug Free Outpatient Txt. Prog. 1990-92

Race / Ethnicity Breakdown

	Af. Am.	As/PI	Hispanic	Native A	White	Other	Unknown
(1)	not stratified						
(2)	not stratified						
(3)	not stratified						

WOMEN WHO HAVE SEX WITH MEN - Non IDU

Prevalence Estimate	95% Conf Int	Study Name
0.36% (9/2509)	0.16 - 0.68	(1) HIV Seroprevalence for Newborn Infants and Their Mothers - 1991 (IDU status not reported.)
0.6% (4/668)	0.2 - 1.5	(2) City Clinic 1992 - Family of Surveys - Het, no other rf
3.6% (5/138)		(3) HIV Infection in Heterosexuals in Alcohol Txt.
0.04% (2/5585)		(4) Kaiser Survey - Northern CA -1989
0.16% (1/623)		(5) AMEN Study
2.8% (4/143)	0.8 - 7.0	(6) Drug Free Outpatient Txt. Prog. 1990-92
0.56% (11/1966)		(7) Abortion Clinic - 1990 - 92
0.8% (5/611)	0.3 - 1.9	(8) Homeless Youth Centers

Race / Ethnicity Breakdown

	Af. Am.	As/PI	Hispanic	Native A	White	Other/Unk.	Comments
(1)	0.95	0.0	0.16	n.d.	0.63	1.04 Unk	
(2)	1.4	0.0	1.3	n.d	0.0	0.0	
(3)	not stratified						
(4)	not stratified						
(5)	0.5	n.d.	0.0	n.d.	0.0	0.0	
(6)	not stratified						
(7)	not stratified						
(8)	not stratified						

HIV Prevalence Data from Studies

WOMEN WHO HAVE SEX WITH MEN - IDU

Prevalence Estimate	95% Conf Int	Study Name
2.8% (2/71)		(1) AMEN Study
7.0% (3/43)	1.5 - 19.1	(2) City Clinic 1992 - IDU Females (may incl. lesb/bi IDU's)
6.0% (5/83)		(3) HIV Infection in Heterosexuals in Alcohol Txt.
6.0% (26/432)		(4) Methadone Txt. Centers - 1992
11.4% (46/403)		(5) HIV Among Female IDU's Recruited from Community Settings - 1991-92
9.6% (34/354)		(6) Drug Injectors and HIV-1 Infection in the SFBA - 1991 Watters
3.5% (6/171)	1.3 - 7.5	(7) Drug Free Outpatient Txt. Prog. 1990-92
24.3% (7/29)		(8) Women Attending an Abortion Clinic - 1990-92
2.8% (2/72)	0.3 - 9.7	(9) Homeless Youth Centers - 1990-92

Race / Ethnicity Breakdown

	Af. Am.	As/PI	Hispanic	Native A	White	Other/Unk.	Comments
(1)	0.0	n.d.	0.6	n.d.	0.4	0.0	
(2)	not stratified						
(3)	not stratified						
(4)	not stratified						
(5)	14.3	n.d.	15.4	n.d.	5.7	13.6	
(6)	not stratified						
(7)	not stratified						
(8)	not stratified						
(9)	not stratified						

MEN WHO HAVE SEX WITH WOMEN - NON-IDU

Prevalence Estimate	95% Conf Int	Study Name
2.3% (36/1574)	1.6 - 3.2	(1) City Clinic 1992 - Family of Surveys - STD Clinic - Het M
6.1% (4/66)	1.7-14.8	(2) City Clinic 1992 - Family of Surveys - STD Clinic - Sex Partner at risk for HIV
2.8% (10/360)	1.3 - 5.0	(3) Drug Free Outpatient Txt. Prog. 1990-92
0.7% (2/302)	0.1 - 2.0	(4) Homeless Youth Centers 1990-92 - Self Identified
2.6% (10/378)	n.d.	(5) HIV Infection in Heterosexuals in Alcohol Txt.
0.3% (3/971)	0.1 - 1.7	(6) Juvenile Detention Center 1990-92
0.44% (21/4733)		(7) Civilian Applicants for Military Service 1985-92

Race / Ethnicity Breakdown

	Af. Am.	As/PI	Hispanic	Native A	White	Other	Unknown
(1)	3.3 (21/632)	2.2 (2/91)	1.9 (7/378)	n.d.	1.9 (10/520)	0 (0/19)	
(2)	not stratified						
(3)	not stratified						
(4)	not stratified						
(5)	not stratified						
	not stratified						
(6)	not stratified						

HIV Prevalence Data from Studies

MEN WHO HAVE SEX WITH WOMEN - IDU

Prevalence Estimate	95% Conf Int	Study Name
7.7% (20/261)		(1) HIV Infection in Heterosexuals in Alcohol Txt.
9% (24/260)		(2) Sexual Behaviors and Sex ID in Male IDU's - 1989
14.3% (85/593)		(3) Drug Inject. and HIV in SFBA - 1991
6.7% (7/104)	2.7 - 13.4	(4) City Clinic 1992 - Family of Surveys - STD Clinic
7.4% (63/849)	5.7 - 9.4	(5) Methadone Txt. Center - 1992
6.3% (29/457)	4.3 - 9.0	(6) Drug Free Outpatient Txt. Prog. 1990-92
0.0% (0/48)	0.0 - 6.1	(6) Homeless Youth Centers 1990-92

Race / Ethnicity Breakdown

	Af. Am.	As/PI	Hispanic	Native A	White	Other	Unknown
(1)	not stratified						
(2)	not stratified						
(3)	not stratified						
(4)	not stratified						
(5)	not stratified						
(6)	not stratified						
(7)	not stratified						

MEN WHO HAVE SEX WITH MEN - Non IDU

Prevalence Estimate	95% Conf. Int.	Study Name
15.4% (58/376)		(1) San Francisco Young Men's Health Study
32% (36/113)		(2) AMEN - AIDS in Multi-Ethnic Neighborhoods
7.4% (26/353)		(3) Young Men's Survey (incl. Bay Area Residents)
34.8% (226/650)	31.1 - 38.6	(4) City Clinic 1992 - Family of Surveys - STD Clinic
48%		(5) San Francisco Men's Health Study - 1990
52%		(6) City Clinic Hepatitis B Cohort Study - 1978-1990 (cumulative incidence) (IDU status not sep.)
33.5% (46/137)		(7) City Clinic 1990 - Voluntary Survey
50.7% (226/446)		(8) City Clinic 1990 - Blinded Survey
51.7% (15/29)	32.5 - 70.6	(9) Drug Free Outpatient Txt. Prog. 1990-92
33.3% (44/132)	25.4 - 42.1	(10) Homeless Youth Centers 1990-92

MEN WHO HAVE SEX WITH MEN - Non IDU (Cont'd.)

Race / Ethnicity Breakdown

	Af. Am.	As/PI	Hispanic	Native A	White	Other	Comments
(1)	35	27	25	n.d.	16	7	(incl IDU's - 44/428)
(2)	63	n.d.	36	n.d.	45	43	(incl IDU's - 39152)
(3)	21.2	4.2	9.5	8.3	8.1	n.a.	(inc. IDU's - 70/425)
(4)	45.1	37.1	37.1	n.d.	32.3	50.0	(inc. IDU's - 50/700)
(5)	not stratified						
(6)	not stratified						
(7)	12.5	n.d.	40.9	n.d.	37.4	12.5	
(8)	64.5	n.d.	61.3	n.d.	45.9	33.3	
(9)	not stratified						
(10)	not stratified						

MEN WHO HAVE SEX WITH MEN - IDU

Prevalence Estimate	95% Conf Int	Study Name
36% (16/44)		(1) San Francisco Young Men's Health Study
59% (23/39)		(2) AMEN - AIDS in Multi-Ethnic Neighborhoods
20.0% (14/70)		(3) Young Men's Survey
38% (19/50)	25 - 53	(4) City Clinic 1992 - Family of Surveys - STD Clinic
48%		(5) San Francisco Men's Health Study - 1988
50.0% (19/38)		(6) City Clinic 1990 - Voluntary Survey
68.9% (82/119)		(7) City Clinic 1990 - Blinded Survey
30.8% (8/26)	14.3 - 51.8	(8) Methadone Txt Centers - 1992
54% (21/39) - Gay 24% (11/45) -Bisexual		(9) Sexual Behaviors and Sexual Identities in Male IDU's - 1989

Race / Ethnicity Breakdown

	Af. Am.	As/PI	Hispanic	Native A	White	Other	Comments
(1)	not stratified						
(2)	not stratified						
(3)	not stratified						
(4)	not stratified						
(5)	not stratified						
(6)	67 (2/3)	n.d.	38 (3/8)	n.d.	50 (13/16)	100 (1/1)	
(7)	65 (7/11)	n.d.	65 (11/17)	n.d.	70 (62/89)	100 (2/2)	
(8)	not stratified						
(9)	not stratified						

HIV Prevalence Data from Studies

Homeless Population

Prevalence Estimate	95% Conf Int	Study Name
8.5% Overall		(1)

Race / Ethnicity Breakdown

	At. Am.	As/PI	Hispanic	Native A	White	Other	Unknown
(1)							

HIV COUNSELING AND TESTING DATA

HIV seroprevalence results from the HIV Counseling and Testing Program were analyzed for first time testers during the period January 1993 to May 1994. Data was provided from over 150 sites throughout San Francisco. The testing sites are located in various locations throughout the city and serve a diverse group of clients. People who choose to be tested are a self-selected sample and may not represent the general population. However, Counseling and Testing programs are a major component of any prevention effort and provide a convenient sentinel indicator of those people who, for some reason, consider it important to be tested.

To assist the HIV Prevention Planning Council in writing the Epidemiologic Profile, Counseling and Testing data was analyzed according to the transmission groups approved by the Council. The results follow a pattern similar to the estimates of HIV infection and results from local published research.

Transmission Group	Number Tested	No. HIV Positive	Percent Positive
Women who have....			
sex w/ women	118	1	0.8%
sex w/ women / IDU	14	3	21.4%*
sex w/ men & women	42	0	0
sex w/ men & women / IDU	5	0	0
sex w/ men	3,033	14	0.5%
sex w/ men / IDU	123	10	8.1%
Men who have....			
sex w/ women	3,528	26	0.7%
sex w/ women / IDU	222	8	3.6%
sex w/ men & women	243	21	8.6%
sex w/ men & women / IDU	36	5	13.9%
sex w/ men	1,273	285	22.4%
sex w/ men / IDU	193	73	37.8%
Transgender	10	1	10.0%*
Other Risk Category (i.e., sex partner at risk)	2,810	119	4.2%
Unknown	1,063	139	13.1%

* Estimated seroprevalence in these categories should be interpreted with caution, due the low number of individuals tested and identified as HIV-positive.

These data show that men who have sex with men have the highest seroprevalence rates, and that injection drug use dramatically increases the seroprevalence among each sexual transmission group. Unfortunately, there were many people who could not be classified into one of the transmission categories approved by the council.

Small sample size limited further breakdown by race/ethnicity and age, however, regardless of transmission category, African American men and women had the highest seroprevalence rates. Although transgender identity is not asked on the Counseling and Testing form, 10 people self-identified as such and only 1 tested HIV positive.

SURROGATE MARKERS

Introduction

Surrogate markers may be used to approximate populations at risk for HIV infection. Many studies reviewed in this plan found that history of a Sexually Transmitted Disease (STD) and/or alcohol and drug use were independent predictors of seroconversion (11,18,21) and high risk behaviors (10,12,14,15,17,19). The relationship between STDs, substance use, and HIV is consistent across all populations and demonstrates the need to integrate prevention efforts in these three areas.

Although other surrogate markers such as teen pregnancy and tuberculosis have not been shown to be accurate markers of HIV risk in San Francisco, they can be seen as social indicators of populations at risk for multiple health problems (including HIV infection).

Methodology

The surrogate markers identified by the HIV planning group were: 1) STDs; 2) Teenage Pregnancy; 3) Tuberculosis; and 4) Substance Abuse. Recent data from the San Francisco Department of Public Health as well as published literature was reviewed. Populations disproportionately affected by the aforementioned surrogate markers are highlighted.

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(not yet published)

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(not yet published)

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SEXUALLY TRANSMITTED DISEASES (STDs)

Introduction

At a minimum, Sexually Transmitted Diseases (STDs) are a marker for unsafe sexual behaviors. In addition, several prospective studies that control for sexual behavior demonstrate that many STDs are risk factors for HIV infection (1). The blinded seroprevalence surveys from 1990 to 1993 were combined to assess the relationship between STDs and HIV among patients attending the only municipal STD Clinic in San Francisco. The blinded seroprevalence rate in this population has been decreasing since 1990, but from 1992 to 1993 it remained stable at 16%.

The results of this analysis showed that overall, patients who were positive for gonorrhea were 2.2 times more likely to be infected with HIV (95% confidence interval = 1.96, 2.48). Similarly, patients who were diagnosed with early syphilis were 2 times more likely to be infected with HIV (95% confidence interval = 1.72, 2.4). The relationship varied by transmission group as shown in the table below. Unfortunately, information on women who have sex with women was not recorded before 1992. Data on this transmission group is now being recorded and will be evaluated in future analyses.

Estimates of Risk for Current HIV Infection for City Clinic Patients Who Had a Current Gonorrhea or Syphilis Diagnosis (1990-1993)

	Gonorrhea (OR; 95% Confidence Interval)	Early Syphilis (OR; 95% Confidence Interval)
Women who have....		
sex w/ men	3.17 (1.27,7.90)	2.87 (1.15,7.16)
sex w/ men - IDU	2.86 (0.87,9.36)	1.45 (0.21,10.1)
Men who have....		
sex w/ men	1.51 (1.35,1.69)	1.56 (1.32,1.83)
sex w/ men - IDU	1.31 (1.02,1.69)	1.50 (1.11,2.01)
sex w/ women	1.60 (1.12,2.30)	2.47 (1.54,3.97)
sex w/ women - IDU	2.04 (0.95,4.38)	2.26 (0.85,6.00)

Such results indicate that populations in San Francisco with high rates of STDs may be at increased risk for HIV infection. Whether seen as a surrogate marker for high risk sexual behaviors or as an actual marker for HIV infection, all reportable STDs should be examined to assess which populations are most affected by STDs and in need of STD and HIV prevention (2).

Although STDs in San Francisco are currently at their lowest reported levels in the past 30 years, rates remain higher than State and National Levels. Furthermore, some populations remain disproportionately affected (i.e., in 1992 African American youth had the highest risk of STDs in San Francisco).

Adolescents

STDs are highly dependent on age, disproportionately affecting adolescents. Rates for gonorrhea and chlamydia are higher for youth than adults. The rates among 15-19 year olds is 3.3 times the overall rates of gonorrhea and 6.9 times the overall rate for chlamydia. Although STDs have been decreasing among youth, they are still above the national rates and CDC's year 2000 objectives. For example, among African American youth (15-19 years) in San Francisco, the rate for gonorrhea is 6,228. CDC's year 2000 objective for 15-19 year olds (overall) is a rate of 750.

African American adolescents have the highest rates for gonorrhea and chlamydia, followed by Native Americans, Latinos, Whites and Asian Pacific Islanders. The greatest decreases over the past five years have been seen in cases among White youth. Native American youth are the only racial/ethnic group for whom cases of gonorrhea and chlamydia have increased (cases of gonorrhea increased from two to six cases and cases of chlamydia increased from two to five cases).

Rates are higher for each STD among females than males. Part of this gender difference may be due to screening efforts (especially for chlamydia) which have aggressively focused on infections among females. The neighborhoods in San Francisco with the highest rates of STD infection among adolescents are: Bayview/Hunter's Point, South of Market and the Western Addition.

Race/Ethnicity

Rates for African Americans are six times higher than rates for Whites for each STD (syphilis, gonorrhea, chlamydia). Similarly, rates for Latino

populations are at least twice the rates for Whites. Decreases in gonorrhea and chlamydia cases have been observed over the past five years among all racial/ethnic groups with the exception of Native Americans, who had an increase in gonorrhea and chlamydia rates. Asian/Pacific Islanders continue to have the lowest rates of STDs in San Francisco.

Geographic Distribution

Geographic trends in STDs tend to follow the distributions of race/ethnicity and socioeconomic status in San Francisco neighborhoods (see social and demographic data in Section C). Rates for gonorrhea are highest in Western Addition, the Sunnydale Projects, Bayview Hunter's Point, South of Market and the Tenderloin. Syphilis and Chlamydia also tend to be highest in these districts. There has been an increasing trend in homelessness among gonorrhea cases from 1988 to 1992.

TEEN PREGNANCY

Introduction

Although not all teenage pregnancies are unintended, looking at pregnancy rates among teens (12 to 19 years) is an indicator of unsafe sexual behavior among young women. The 1992 San Francisco Resident Teen Birth Statistics is an annual report produced by the San Francisco Department of Public Health (3). According to this report, of the 9,566 births to San Francisco residents in 1992, 721 (7.5%) were to young women between the age of 13 and 19 years. Of the 721 teen births, 76 (11%) were to teens in the age group of 13-15 years, 213 (30%) were to those between the age of 16 and 17 years old, and 432 (59%) were to 18-19 year olds.

Race/Ethnicity

Over a third (33%) of all teen births were to African Americans, 29% to Latinas and 9% to Whites. Of school age teens, African Americans comprised 46% of teen births to mothers between 12 and 15 years old and 41% in those between 16 and 17 years of age.
Although African American births comprised only 14.4% of all births in San Francisco in 1991, African Americans accounted for a disproportionate 46% of all births to school-age teens (4).

Teen Fathers

The majority of fathers of teen births (45%) were between the ages of 20 and 25 years. Teen fathers (16 to 19 years) comprised 217 or 30% of all teen births. The highest incidence of teen birth fathers were among African Americans (238; 33%) and Latinos (207; 29%).

Geographic Distribution

The San Francisco neighborhoods with the highest numbers of teen births were the Inner mission (22%), Ingleside/Excelsior (14%), and Bayview/ Hunter's Point (12%).

TUBERCULOSIS

Introduction

There has been a lot of speculation that the AIDS epidemic is partly responsible for the reemergence of Tuberculosis (TB) in the United States (5). In large cities such as New York, where there is a great deal of overlap between HIV and TB infection, TB can be thought of as a surrogate marker for HIV infection. However, in San Francisco Tuberculosis is not as large of a problem and so far, does not appear to be a very useful surrogate marker for HIV infection.

A recent study of HIV and TB in a representative sample of homeless adults in San Francisco found no evidence of an association between TB and HIV infection, even after controlling for anergy (6). The prevalence of TB infection in this sample of 1,226 homeless adults was 34% in the HIV-negative subjects compared with 19% of the HIV-positive subjects. However, injection drug use and related behaviors were strong risk factors for both TB and HIV infection, especially in homeless women.

Future research should investigate the predictive value of TB as surrogate marker for HIV infection and should monitor any relationship between HIV and TB infection. Tracking the number of TB cases in the San Francisco, the neighborhoods most affected and the number of TB cases with AIDS will be an important part of understanding and monitoring such relationships.

TB Cases with AIDS

In 1993, the new AIDS case definition was changed to include HIV infection and any form of TB. The following table shows the number of TB cases with AIDS by year. It is clear that the number of cases of TB with HIV infection continues to be a problem in San Francisco (7).

Year	# TB Cases	# TB Cases w/ AIDS	% Total Cases
1988	313	54	17.3%
1989	286	61	21.3%
1990	334	75	22.5%
1991	333	77	23.1%
1992	355	82	23.1%
1993	356	85	23.9%

Geographic Distribution

Census data indicates that the Tenderloin area has the highest incidence of Tuberculosis. Efforts in this area concentrated on the homeless living in shelters as TB cases among transient populations remain disproportionately high (16% of the total cases in 1992 were among transient populations).

SUBSTANCE ABUSE

Introduction

Any HIV prevention effort must also address individual and community level substance abuse problems. City-wide alcohol and drug use data may illuminate populations who are disproportionately affected by substance abuse and may be at risk for HIV infection. Unfortunately, there is not one source of data for the entire city.

The San Francisco Department of Public Health's Community Substance Abuse Services collects comprehensive data on all residential treatment programs, County programs and other contract treatment programs. However, this data is not representative of populations that seek private treatment or those who are not in any type of treatment program (i.e., only about 25% of IDUs are in treatment).

Published research can use specific sampling such as street recruitment to reach an out of treatment population, but such samples are often not representative either. Thus, multiple sources of data on alcohol and drug use need to be examined.

Alcohol and Drug Treatment Programs (Demographics)

Women comprised 29% of alcohol and drug treatment episodes for the 1991/1992 fiscal year. The racial/ethnic breakdown of patients seeking treatment during this time was: 42% African American, 7% Latino/Hispanic, 2% Asian, 2% Native American and 47% White. Forty seven percent reported injection drug use of their primary drug. Employment status at admission revealed that 64% were unemployed and 11% disabled (8).

Injection Drug Use

With an estimated 16,000 Injection Drug Users (IDUs) in San Francisco, the City is number one in the US for heroin emergency room rates (8). Heroin use is reported as the primary drug problem of 49% of those who sought alcohol and drug treatment during the 1991/1992 fiscal year. AIDS cases among heterosexual IDUs have increased from 4.9% in 1989 (95/1934) to 8.9% in 1993 (207/2325). There were no increases in AIDS cases among gay or lesbian IDUs (9).

In the San Francisco Young Men's Health Study of gay and bisexual men between 18 and 29 years, 10.2% reported injection drug use. The injectors in this study were 2.5 times more likely to be HIV positive (10). In a sample of female IDUs recruited from street settings, Watters et al. reported an overall seroprevalence rate of 11.4% (18).

In a population based survey of several low income neighborhoods in San Francisco, 11% injected drugs, with slightly higher rates in the Western Addition. In addition, 7% of this population based sample had an IDU partner (11). Initial results from the AIDS Evaluation of Street Outreach Project (AESOP) found that 31% of street youth had injected drugs (20).

Crack and Cocaine Use

San Francisco ranks third in the US. for cocaine emergency room rates. Crack use is reported as the primary drug problem of 23% of those who sought alcohol and drug treatment during the 1991/1992 fiscal year. Cocaine injection and crack use have been associated with high risk sexual behaviors and needle sharing behaviors among IDUs and non-IDUs (12-16). The population based AMEN study found that 9% of the total sample used crack, and 20% of those sampled in Bayview/Hunter's Point used crack (11).

Alcohol Use

Alcohol use is reported as the primary drug problem of 21% of those who sought alcohol and drug treatment during the 1991/1992 fiscal year. A recent study of heterosexuals in alcohol treatment programs found seroprevalence rates that were much higher than those found in a random household probability sample of heterosexuals in the communities where the treatment population lived (even when controlling for injection drug use). The reasons for high seroprevalence rates in this population are unknown, but high risk sexual behaviors were common (17).

BEHAVIORAL DATA

Introduction

Identifying populations at high risk for HIV infection requires more than collecting seroprevalence and seroincidence data and tracking the disease over time. Understanding high-risk sexual and drug use behaviors of diverse populations and identifying the determinants of HIV-preventive behaviors are essential components in the development of prevention strategies. This understanding will also be necessary in order to redirect priorities to those populations who continue to engage in high-risk behaviors in spite of targeted prevention programs. As the HIV-prevention needs of different populations change over time, continuous assessment of identified high-risk behaviors will be critical in determining how to respond to those changes and adapt behavioral interventions.

The lack of standardized measures for assessing different behavioral constructs and the absence of a systematic behavioral surveillance system in San Francisco makes cross-study and cross-population behavioral comparisons difficult. There are certain behaviors that have been determined to be associated with HIV infection (i.e., number of sexual partners, type of sexual activity, condom use, history of STD infection, alcohol and drug use), as well as psychosocial factors that appear to mediate high risk behaviors and behavior change (i.e., perceived risk, perceived efficacy, and peer support). Unfortunately, the measurement of these variables across studies varies dramatically.

As more and more community-based organizations turn to behavioral research that is grounded in behavior change theory to guide prevention activities, the need for reliable and consistent standardized measures of risk behaviors is extremely important. The fluid nature of current behavioral measures makes it difficult to evaluate prevention programs that may be delivered to quite different at-risk populations. The effects of race, ethnicity, culture, sexual orientation, gender, age, and socioeconomic status, among other factors, is difficult determine in the absence of standard measures of risk behaviors.

Methodology

In an effort to understand the behavioral risk of diverse populations, local and recent (after 1989) published behavioral studies and program level KABBs were reviewed. It was hoped that this data could be analyzed

according to the twelve transmission groups used throughout the epidemiologic profile. From this larger pool of information, behavioral summaries would be generated that would highlight specific risk-behaviors and their determinants. However, published research tends not to be organized according to transmission groups. Thus, a behavioral analysis was conducted according to populations that emerged from published literature.

The behavioral analysis and summaries highlight the key behavioral findings of the studies for each population. The implications for the development and revision of current and future approaches to HIV-prevention resulting from this behavioral research is included. Each section ends with a series of suggestions for future behavioral research for each population. The implications for prevention and suggestions for future research are those noted by the authors of the published literature.

Unfortunately, no behavioral studies or KABBs could be identified for transgender or immigrant populations. Initial qualitative research indicates that both groups are engaging in high risk behaviors and should be the focus of future behavioral research and KABBs. The needs assessment chapter includes a summary of the qualitative data findings for these two populations.

PUBLISHED BEHAVIORAL STUDIES AND KABB BEHAVIORAL SUMMARIES:

List of Populations

Drug Users:

1. Injection Drug Users and Their Sexual Partners
2. Populations in Drug Treatment (Non-IDU)
3. Populations Who Use Crack
4. Gay/Bisexual Men Who Use Poppers

Youth Populations:

5. Young Gay/Bisexual Men
6. In School Youth
7. Homeless/Runaway Youth
8. Point of Entry Studies: Incarcerated Youth and Clinic Based Studies of Youth

Sexual Orientation (Adults):

9. Gay/Bisexual Men
10. Lesbian/Bisexual Women
11. Heterosexual Men and Women / Women Only Studies

Other High Risk Adult Populations:

12. Populations in the Sex Industry
13. Adults in the Criminal Justice System
14. Homeless Adults

Race/Ethnicity:

15. African American/Black
16. Asian/Pacific Islander
17. Latino/Hispanic
18. Native American

INJECTION DRUG USERS AND THEIR SEXUAL PARTNERS

Published Behavioral Studies:

1. HIV Infection Among Female Injection Drug Users Recruited in Community Settings.
Watters JK, Estilo MJ, Kral AH, Lorvick J
(not yet published).

2. Predictors of Needle Sharing Behavior Among IDUs Entering Treatment.
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3. HIV Seroconversion in Intravenous Drug Users in San Francisco, 1985-1990.
Moss AR, Vranizan K, Gorter R, Bacchetti P, Watters J, Osmond D.
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4. Sexual Behavior and Identity in Male I.V. Drug Users.
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8. Sexual Risk Behavior Among Heterosexual Intravenous Drug Users: Ethnic and Gender Variation.
Lewis DK; Watters JK.
Aids, Jan 1991, 5(1):77-83.

9. Drug Use Profiles, Race, Age and Risk of HIV Infection.
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10. AIDS Prevention for Intravenous Drug Users in the Community: Street-Based Education and Risk Behavior.
Watters JK, Downing M, Case P, Lorvick J, and others
American Journal of Community Psychology, 1990 Aug; 18(4): 587-596.

Sexual Partners of IDUs

11. AIDS Knowledge, Perception of Risk, and Behavior Among Female Sex Partners of Injection Drug Users.
Carbo NH, Wolitski RJ, Thronton-Johnson, Tanner WM
AIDS Education and Prevention, 1991; 3(4): 353-366

12. The Prevalence of High-Risk Sexual Behavior in Male Intravenous Drug Users with Steady Female Partners.
Lewis DK, Watters JK, Case P
American Journal of Public Health, 1990; 80(4): 465-466

INJECTION DRUG USERS AND THEIR SEXUAL PARTNERS

Behavioral Summary

It is estimated that there are between 13,000 and 16,000 Injection Drug Users (IDUs) in San Francisco. As a whole, IDUs are a population that demonstrate that behavioral interventions can work. Intense interventions aimed at altering needle sharing practices (needle exchange programs, street outreach, and counseling and testing) have had an impact on the needle using patterns of this population. However, high risk sexual behaviors have been more difficult to change and positive changes in needle sharing need to be maintained.

Overall, the high prevalence of sexual risk-taking among IDUs indicates the potential for widespread secondary HIV transmission. In one study of seroconversion in IDUs from 1985-1990, the strongest risk factor for HIV infection among women in this drug treatment population was number of sexual partners (women had a higher rate of seroconversion than men). Such data suggest that understanding the sexual behaviors of IDUs is becoming increasingly important in prevention efforts. The sexual and drug using behaviors and exposure to HIV infection can vary significantly within age, ethnic, gender, sexual orientation and drug preference subgroups.

Among female IDUs (regardless of their sexual orientation), having unprotected sex with men appears to be the principle risk factor for HIV infection. Among male IDUs, sexual risk factors such as multiple partners and low levels of condom use are also evident. In one study of male IDUs, 77% of gay men, 56% of bisexual men, and 18% of heterosexual men reported prostitution. This study also found that there was a great deal of variation in the stated sexual orientation of behaviorally bisexual men.

Differences in drug preference subgroups generally found that among IDUs, cocaine injectors engaged in higher risk sexual and needle sharing behaviors. In addition, crack smoking IDUs were more likely to report high risk behaviors such as exchanging sex for money or drugs, multiple partners, and in one study, injecting in shooting galleries. Because injection cocaine use is more common among crack users, and both types of drugs appear to be linked to high risk behaviors, special attempts should be made to reach those populations who use crack or inject cocaine (i.e., African-American women).

It is not clear if there are age differences in drug of choice, sexual behaviors and needle sharing behaviors among IDUs in San Francisco. Most of the in-

treatment studies predominantly sampled adults and participants for the Urban Health Study must be at least 18 years old. Initial results from the AIDS Evaluation of Street Outreach Project (AESOP) in the Haight Ashbury Neighborhood and the NIDA study of youth in the tenderloin area indicate that injection drug use and sharing of needles among street youth warrants attention. These projects should be closely followed as results become available to see if age differences among IDUs indicate the need for more specific prevention for youth who inject drugs.

Non-injecting partners of IDUs may also be at risk of HIV infection. One study of non-injecting female partners of male IDUs found that 95% engaged in unprotected vaginal sex in the past six months and condom use was very infrequent with main partners. In addition, many of these women had a history of injection drug use and may be at risk for relapse. Another study of IDU men found that 44% of the African Americans sampled had steady sex partners who did not inject drugs.

Recommendations for Prevention

Because most IDUs are not in treatment, street based interventions aimed at behavior change through a harm reduction model are imperative. Syringe exchange was shown to be a strong independent predictor of not sharing needles and syringes, but to be more effective these programs should be culturally appropriate for different IDU groups. Similarly, counseling and testing programs appear to have an effect on decreasing high risk behaviors among IDUs, and such programs should be specifically designed to address the needs of IDUs. Prevention programs will need to reach the environments where cocaine injecting individuals and crack smoking injectors are using because these behaviors may decrease the likelihood of safe sex or needle use.

For those IDUs who are in treatment (about 25%), it appears that education and prevention programs have been effective in decreasing unsafe injection practices, but treatment programs should also incorporate sexual risk reduction interventions. Multiple patterns of drug use are common and treatment needs to be appropriate for polysubstance users.

All prevention programs should be responsive to different ethnic, gender, sexual and drug preference subgroups in order to address the behavioral differences between these groups. Such prevention should emphasize negotiation skills for condom use and needle sharing. Efforts should also be made to reach non-injecting partners of IDUs.

Recommendations for Future Research

Future research should focus on the stability of behavior change over time and factors that mediate compliance with safe sex and needle hygiene. Studies should also address ways to overcome barriers to condom use and should evaluate if communication and negotiation skills development is effective in increasing safer sex and injection behaviors.

Research should focus on specific differences in sexual behaviors (such as differences between main and other partners) and should differentiate between how IDUs self-identify sexually and their sexual behaviors. For example, initial research suggests that female IDUs who self-identify as lesbian or bisexual may be at higher risk of infection because they have sex with gay/bisexual men.

Future research should also investigate the somewhat invisible populations of street youth who inject. Specific street sampling techniques (similar to the Urban Health Study) for youth may be necessary to understand if there are age differences in injection and sexual behavior risks for young injectors and to obtain baseline behavioral data to evaluate future interventions. More studies of non-injecting men and women who are partners of IDUs are needed to determine their risk for infection and design appropriate prevention programs.

HIV Infection Among Female Injection Drug Users Recruited in Community Settings; Watters JK, Estilo MJ, Kral AH, Lorvick J (Not yet published)

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• 407 survey questionnaires and matched HIV serologies from female IDUs • Recruited from community settings in 3 Inner-city neighborhoods in SF during 1992 and 1993 were analyzed • IV drug use was verified by looking for visible signs of recent use & then women were interviewed using a standard questionnaire • Respondents were paid for participation, given pretest & post-test counseling and appropriate referrals	• 47% Afr-Amer • 13% Latino • 35% White • 6% other • Median age = 38 • HIV prevalence = 11.4% • HIV highest among African Americans (14%) and Latinas (15%) compared to Whites (6%)	• 81% reported heterosexual activity involving penile penetration in the previous six months • Frequent users of cocaine had greater numbers of partners and more frequent incidents of penetrative intercourse • 44% of seronegative women and 13% of seropositive women reported that they never used condoms during intercourse • 79% of seronegative and 41% of seropositive women w/ a steady partner reported never using condoms • 22% of seronegative women reported the objection of their sexual partner as the main reason for not using condoms during sex with their steady partner	• 54% reported using crack cocaine in past 30 days • Recent crack smoking was more prevalent among African-American women • Crack smokers were more likely to report illegal activity as their major source of current income, homelessness, ever being pregnant, a history of gonorrhea, multiple sex partners in the past six months, ever receiving $ or drugs for sex • Of the 230 women who reported having a current male steady sexual partner, crack smokers were more likely to have a non-IDU partner • Crack smokers were less likely to report enrollment in drug treatment and any use of syringe exchange	Predictors of HIV infection using multivariate analysis: • History of syphilis, which is a marker or high risk sexual behavior • History of receiving money for sex Protective factor: • Having a stable relationship ** injection related risk factors did not help predict HIV infection in the logistic regression model, when adjusting for race & sexual behaviors.	• Unprotected heterosexual activity is a principal risk factor for HIV infection among female IDUs in SF and has had a more profound effect than injection risk behavior among female IDUs in acquiring HIV infection • IDUs who practice high risk sexual behavior (especially African Americans and Latinas) are important targets for renewed health education and HIV prevention efforts. These efforts should target women w/ a history of sex-trade activity as well as their male clients and other partners. Most successful efforts will take into account the relationship between sexual conduct, economic conditions and chemical dependencies • Greater reported sexual risk behavior of crack smokers was not reflected in higher HIV rate at present, perhaps due to lower prevalence of HIV among their sexual partners	• Non random sample, thus results may not generalize to all IDUs or to crack smokers who do not also inject drugs • Six month or 30 day assessment period for some categories may represent correlates of seropositivity that post-date infection • Self-reports of drug use and risk behavior are subject to the problems of intoxication and factors related to social desirability and psychological functioning

Predictors of Needle Sharing Behavior Among IDUs Entering Treatment NIDA Grant & UCSF, CAPS
Woods W, Grinstead OA, Guydish J, Abramowiz A, Clark W, Hearst N (not yet published)

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross sectional review of records • Between July 1988 and June 1989 • 3,905 IDUs who were first admission to public funded treatment centers • Records were analyzed to determine correlates of needle sharing	• 64% male • 25% Afr-Amer • 13% Latino • 25% White • 4% other • 74% were detox admissions 2% residential, 8% out-patient, and 15% methadone maintenance.		• 93% reported heroin as their primary drug problem • 33% reported any type of cocaine use • Overall, 25% of respondents reported sharing needles in the past 30 days	Predictors of higher rates of needle sharing: • young age • cocaine use • White or Hispanic Predictors of lower rates of needle sharing: • More previous experience in drug treatment	• The finding that previous drug treatment reduces the likelihood of needle sharing suggests that IDUs are learning about HIV prevention via safer injection practices in their treatment programs • Future studies must determine the primary route(s) of transmission of HIV among IDUs in order to provide effective prevention services (i.e., African-Americans had low needle sharing behaviors, but high rates of HIV infection) • Because cocaine users (regardless of route of administration) were more likely to share needles, treatment programs should include AIDS education regardless of clients' stated drug of choice • Future research should investigate the relationship between non-injection cocaine use & needle sharing	• Study included only 2% of IDUs who reported cocaine as primary drugs, and this is unlikely to be a representative sample of cocaine injectors • Cocaine use included any route of use • Findings are limited to drug users entering drug treatment (25% of the estimated 16,000 IDUs in SF participate in county funded treatment programs each year)

HIV Seroconversion in Intravenous Drug Users in San Francisco, 1985-1990
Moss AR, Vranizan K, Gorter R, Bacchetti P, Watters J, Osmond D.
AIDS 1994; 8:223-231

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• 2,351 heterosexual IDUs from all methadone maintenance and 21-day detox programs in San Francisco • 681 were seronegative at first visit and seen at least twice ("repeaters") • Subjects were accessed, interviewed, provided a blood sample and reimbursed for participation • Seroconversion rates are estimated in the repeaters • Comparable data on another group of IDUs (Urban Health Study) obtained between 1986 & 1989)	• 58% male • 26% Afr-Amer • 14% Latino(a) • 52% White • 8% other • 11% were HIV positive at first visit (24% Afr-Amer, 8% • Latino, 7% White)	Changes in sexual behaviors: • Proportion of IDUs only one or no sexual partners in the past year increased from 40% to 67% • Proportion of women who reported being paid for sex fell from 32% to 15%	Changes in drug using behaviors: • IV cocaine use fell from 40% among those seen in 1986 to 15% among those seen in 1990 • IV amphetamine use declined from 13% to 4%, but heroin use increased steadily during the same period. • Data on crack use were obtained only from 1988 to 1990, and has stayed between 20% and 24% • Among those who reported sharing needles, use of bleach increased from 31% in 1986 to 60% in 1990, but the proportion sharing with more than one person fell from 51% to 34%. • Proportion who reported sharing with 2 or more people w/out bleach fell from 26% to 6%	Predictors of seroconversion among repeaters: • Lower age and black ethnicity were associated with seroconversion. When adjusting for these demographic variables 4 factors emerged: • 5 or more partners in past year • Current IV cocaine use and crack use (marginally) • Lifetime use of shooting galleries time spent in methadone maintenance was protective • All of these factors were particularly predictive for women	• The decline in seroprevalence corresponds with a self-reported decline in the principal risk factors for infection, however, overall seroconversion in black IDUs was four times higher than Whites and the seroconversion rate was higher among women than men • The strongest risk factor for HIV infection in the drug-treatment population (certainly among women and possibly overall) is now number of sexual partners, perhaps in association with crack use. • 12 of the 22 converters were women and their seroconversion rate was higher than in men (consistent w/ the greater ease of male-to female transmission of HIV) • These data suggest that heterosexual transmission plays a major role in new HIV infection among IDUs in San Francisco. New intervention efforts should probably be directed at heterosexual transmission as well as at drug-use risk	• Repeaters in treatment may not represent the general population of IDUs, however, they do seem to be representative of IDUs in the treatment system as a whole • Condom use and sex with primary and outside partners were not assessed

Sexual Behavior and Identity in Male I.V. Drug Users
Lewis DK, Watters JK
Journal of Acquired Immune Deficiency Syndromes, 1994; 7:190-195

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• 396 male drug users surveyed in 1989 as part of a larger survey Respondents were contacted in three street settings and two drug treatment programs • A structured questionnaire was administered as an interview • Women and men who did not have sex in the last six months were excluded from analyses	• 45% Afr-Amer • 17% Latino • 34% White • 4% other Behavioral sexual orientation in past 5 yrs • 76% heterosexual • 12% bisexual • 12% homosexual half of behavioral bisexuals self-identified as heterosexuals • African- Americans comprised the largest number of behavioral heterosexuals. • Mean age = 35 for bisexuals, 34 for homosexuals and 38.5 for heterosexuals	• 47% were monogamous in the last 6 months. • Bisexuals and homosexuals were more likely than heterosexuals to report two or more sexual partners • 47% of heterosexuals, 42% of bisexuals and 36% of homosexuals with multiple partners reported never using condoms • 77% of homosexuals, 56% of bisexuals and 18% of heterosexuals reported prostitution • Men who exchange $ or drugs for sex, reported similar rates of never using condoms noted above • Gay or bisexual men were most likely to state they made substantial changes in their behavior to lower their risk of infection (however, reported condom use in past 6 months was still low)	• All were IDUs, but this article concentrated on sexual behaviors	• History of exchanging sex for $ and/or drugs was the only independent predictor of multiple sexual partners	• Behavioral bisexuals showed considerable variation in their self-identification • Many men who stated they reduced sexual risk continued to report no use of condoms. • Interventions must highlight, for both male and female IDUs, the risk of unprotected anal and vaginal intercourse • Drug treatment programs, STD clinics, prisons and outreach programs that target IDUs in non institutional settings • Because some behavioral bisexual men may not acknowledge sexual contact with men, it will take great sensitivity to reach them • All groups of IDUs require continuing intervention to increase compliance with safe sex and needle sharing guidelines and prevent relapse to risky behavior	• Generalizability to other drug-injecting populations is problematic due to targeted sampling • Self-reports of sexual practices may be biased by problems of recall or intoxication • The relatively high levels of prostitution reported by homosexual and bisexual men may not be representative of other IDU communities • The small number of bisexuals and homosexuals (self-reported) limited the level of analysis possible and made comparisons less reliable • Latinos and African Americans may not have admitted to bisexuality or homosexuality due to views disapproval prevalent in their community

Syringe and Needle Exchange as HIV/AIDS Prevention for Injection Drug Users
Watters JK, Estilo MJ, Clark GL, Lorvick J
Journal of the American Medical Association, January 1994; 271(2):115-120

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• 11 semiannual cross-sectional surveys collected as part of the Urban Health Study between December 1986 and June 1992 which surveyed IDUs in 3 inner-city communities and two drug detoxification clinics. • Communities chosen for study were selected for high densities of IDUs • 572 were excluded from analyses because they reported no current injection drug use, leaving 5,644 interviews to evaluate • Correlates of needle sharing were identified using a pool of 752 unduplicated respondents from the two most recent full data collection periods (fall 1991 to spring 1992)	•69% male •45% Afr-Amer •14% Latino •34% White •6% other •78% unemployed •32% homeless (question added in 1990) •18% < = 30 yrs •49% 31-40 •34% > = 41		• From 1987 to 1992 there was an increase in syringe exchange as their usual source of syringes • Decrease in the median number of daily injections in the year prior to the interview (from 1.9 per day to .7 per day) • There was a significant decline persons who reported first injecting drugs in the previous yr (3% to 1.1%) • Decline in sharing behavior from 66% to 36%	Predictors of Needle Sharing in past 30 days (logistic reg.): • Frequency of injection of cocaine in past 30 days Protective factors: • Greater frequency of syringe exchange use in past year • Increasing age • African-American • Condom use 100% of time with penetrative intercourse • Having previously received an HIV antibody test result	• Syringe exchange use was a strong independent predictor of not sharing needles & syringes and such programs should be culturally appropriate for different IDUs • Younger IDUs were more likely to report needle sharing overall, but were less likely to report needle sharing w/ more frequent use of syringe exchange. Thus syringe exchange appears to have had its greatest benefit among younger users • Prevention programs should emphasize negotiation skills for condom use & needle sharing • Prevention programs will need to reach the environments where cocaine injecting individuals are using • C& T programs should address the needs of IDUs	• Generalizability to other drug-injecting populations is problematic due to targeted sampling • Data may be subject to problems of recall, intoxication, socially desirable responses • Use of short time frame (30 days) for some items in a limitation, however, the use of longer periods may introduce recall bias

Crack Use and Human Immunodeficiency Virus Infection Among San Francisco Intravenous Drug Users
Wolfe H, Vranizan KM, Gorter RG, Keffelew AS, Moss AR
Sexually Transmitted Diseases, March-April 1992; 111-114

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross sectional design • Interview survey • Between 1988 and 1990 • 1,281 heterosexual IDUs were recruited from heroin treatment programs	•59% men •27% Afr-Amer •15% Latino •59% White •med age = 37 yrs	• Crack users were more likely to report 6 or more sex partners in past year (15% vs.. 9%) • Female crack users were more likely than other women to report having received payment for sex (30% vs.. 19%)	• 23% reported using crack in the past 30 days • Women were more likely to report crack use than men and they used it more heavily • Crack use was more prevalent among African - Americans (47% vs.. 14.5%) • 58% of African-American women reported crack use • IV cocaine use was more frequent among crack users (35% vs.. 20%) • Crack users were significantly more likely to report injecting in shooting galleries in past year	Predictors of HIV infection: • Seropositivity was 10% among the study population as a whole • Crack use was marginally significantly associated with HIV after controlling for demographic variables with logistic regression • Number of partners (6 or more past yr) was the only behavioral variable that predicted HIV infection in logistic model	• The strong association between crack use and African-American race suggest a pooling or segregation effect (engaging in same behaviors may pose greater risk for African-Americans than other racial ethnic groups). • Crack use in the IDU population is a marker for other risk behaviors. The observed association w/ HIV infection probably reflects a greater number of sexual partners among crack users and increased exposure through IV cocaine use • This study suggests that heterosexual transmission of HIV may be of increasing importance in IDUs, particularly among African-Americans who also use crack.	• Most subjects were enrolled in treatment programs, limiting the generalizability to street based populations • Other sexual behaviors such as condom use and differences between partner types were not measured • Needle sharing behaviors were not evaluated

Sexual Risk Behavior Among Heterosexual Intravenous Drug Users: Ethnic and Gender Variation Lewis DK, Watters JK
AIDS, 1991; 5:77-83

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross sectional sample. 45 minute interview • 457 IDUs recruited from 21 day detox programs and street based sites • Entry criteria included being in treatment or for street based sites, reported needle use w/ in 3 weeks and visible signs of recent injection • Response Rate: 86% among IDUs in clinics. No response rate listed for street respondents	• 37% female • 52% Afr-Amer • 48% White • 79% of African-Americans and 50% of Whites were interviewed in street setting • Latinos and other groups were excluded because of small numbers.	• 65% of respondents had 2 or more partners in past year • 22% of Whites and 14% of African- Americans reported 10 or more partners • Women were more likely than men to report 10 or more partners (23% vs.. 15%) • 15% of all respondents reported same sex partners in past year • 35% reported prostitution in the past year • African-Americans and Women were more likely to report exchanging sex for money • Whites and women were more likely to have a consistently stable partner who injected drugs • 73% of men and 61% of women said they never used condoms		• Respondents with more than 10 sexual partners, men who have sex with other men, and respondents who engaged in prostitution were all more likely to use condoms • Women were more likely than men to report condom use (even among those who engaged in prostitution)	• The high prevalence of sexual risk-taking of this sample indicates the potential for widespread secondary HIV transmission (this risk taking was higher among Whites than African-Americans • The gender differences in condom use indicate that AIDS prevention programs should be targeted to men • Outreach programs should also inform non-injecting partners of IDUs and the need for more outreach prevention is particularly critical in the African-American community where 44% of black IDUs reported steady sex partners who did not inject drugs • Culturally appropriate drug treatment and intervention programs are needed for African-Americans (almost half were not in treatment)	• Non-random sample • Based on self-reported behaviors • Did not ask intravenous-drug-using status of casual partners

Drug Use Profiles, Race, Age and Risk of HIV Infection
Watters JK, Cheng YT, Lorvick JJ
International Journal of Addictions, 1991; 26(12):1247-1261

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross sectional sample • 1987 • Interview survey • Participants paid for participation • 623 IDUs recruited from 3 street locations & drug detox clinics • Recruitment was controlled to insure adequate representation of targeted groups • Men who reported sex w/ other men were excluded from sample			• There was a tendency for multiple drug injection • Two groups of drug injection profiles were created w/ different rates of HIV infection (17% for the higher and 9.8% for the lower) • In multivariate analysis only age (being younger than 30 yrs) and race (African-American) contributed to likelihood of HIV infection.		• African-American IDUs under 30 are at greatest risk of HIV infection (seroprevalence = 43.5%) • Although daily use of cocaine has been associated with HIV infection in other studies, it was not significant in this sample • Multiple patterns of drug use injection and habituation require treatment strategies & prevention efforts for multiple drug users • Existing methadone modalities need to be augmented w/ treatments more appropriate for polysubstance use, especially the use of stimulants	

AIDS Prevention for Intravenous Drug Users in the Community: Street-Based Education and Risk Behavior
Watters JK, Downing M, Case P, Lorvick J, Cheng YT, Fergusson B
American Journal of Community Psychology, 1990; 18(4): 587-596

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Two cross-sections sampled from drug detox clinics and street locations • Interview survey on behavior change associated w/ street based AIDS education was evaluated • 1986 (n=438) • 1987 (n=623)	• In 1987 more participants were recruited from the streets which had the effect of increasing the proportion of respondents that were over 35 yrs old, African-American, less educated and not enrolled in drug treatment	• In 1986, 22% of the participants reported using condoms, but only 4.3% used them at least half of the time. In 1987, 32.7% reported using condoms and 18.6% reported using them at least half of the time	• In 1986, 30% reported cleaning their needles the correct way, but in 1987 63% reported doing this • In 1986, 9.8% reported not sharing needles, but in 1987 21% reported this		• Street based outreach programs of the type studied here my be an effective means of reaching IV drug users who are not in treatment • Future research should focus on the stability of behavior change over time and the factors that mediate compliance with safe sex and needle hygiene • Prevention programs would be specific to different ethnic, gender & drug preference subgroups since risk behaviors & HIV exposure can differ substantially w/ in them	• Sample used is not random, so generalizability is limited • Change in the composition of the sampling frame from 1986 to 1987

AIDS Knowledge, Perception of Risk, and Behavior Among Female Sex Partners of Injection Drug Users
Carbo NH, Wolitski RJ, Thronton-Johnson S, Tanner WM
AIDS Education and Prevention, 1991; 3(4):353-366

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross sectional design • Interview (KABB) • Administered to 137 female sex partners of male IDUs • Participants were recruited in Long Beach CA as part of a longitudinal study of HIV risk among IDUs and their female sex partner • December 1988-Nov. 1990 • Targeted sampling approach used • Entry criteria: being 18 years or older who did not use injection drugs in the past 6 months	• [illegible]fr-Amer • 23% Latina • 20% White • 91% of Latinas were of Mexican decent • mean age = 32 yrs • 6% lived on the streets and 4% were in shelters • 63% had been in jail at some time in their life • Of the 123 women tested, 3.3% were HIV positive	• 95% reported engaging in unprotected vaginal sex in the past 6 months • 7% reported unprotected anal sex • 20% reported that they had engaged in prostitution in the past 6 months • 39% had history of STD • 67% had only one sexual partner in the past six months • Condom use was less frequent w/ main partners • Most frequent reasons for not using condoms were 1) the belief that a male partner would object to condom use and 2) personal dislike of condoms	• 67% used non-injection drugs • 45% used crack • 32% reported prior use of injection drugs (56% of whites, 31% of Latinas, and 24% of African Americans) • 20% reported daily alcohol use • 20% were or had previously been in drug treatment	Predictors of high risk behaviors: • African American women were more likely than Latinas and Whites to have been diagnosed w/ syphilis, have multiple sex partners, engage in prostitution, use crack cocaine and drink alcohol daily (3 of the 4 positive women were African American)	• Prevention should encourage the use of condoms among male injectors (especially those w/ a steady partner) because women may feel unable to get their partner to use condoms • Because about a third of the women had injected drugs in the past, programs aimed at preventing relapse and promoting safe needle use should be developed. Such programs should also be developed for women's sex partners. • Because women who used alcohol daily and used crack were more likely to engage in prostitution, prevention programs should also address non-injection drug use. • Risk reduction should aim to increase the perceived benefits of condom use. Such programs should as be designed to influence the attitudes and behaviors of the male partner	• This is not a SF sample, however, partners of IDUs have not been studied in SF and are an important group to look at • The convenience sample may to adequately represent important subgroups and characteristics of this population • Purposely excluded women who injected in past 6 months, but a third had injected in the past (this variable was not looked at w/ seroprevalence)

The Prevalence of High-Risk Sexual Behavior in Male Intravenous Drug Users with Steady Female Partners
Lewis DK, Watters JK, Case P
American Journal of Public Health, 1990; 80(4):465-466

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross sectional survey administered as an interview to 149 male IV drug users in treatment and street settings • 1987 • Entry criteria was having a stable female partner 34 men who had exclusively male sexual contacts in past 5 years and others who did not have a steady female partner were excluded (also those w/ a steady male partner)	• 79 were Afr-Amer • 70 were White • 18% were married • Mean age of African-Americans was 36, and it was 33 for Whites	• 83% reported more than one female sexual partner in the past 5 yrs • 60% had 5 or more • 39% had 10 or more • 15% reported sexual contact w/ a male (this is after excluding those w/ primary male partners & those w/ exclusive male contacts) • Heterosexual anal sex was reported by 38% • 73% never used condoms 33 White and 23 African American subjects reported male sexual contact or heterosexual anal intercourse			• The numerous sexual partners and high risk practices reported by these IV drug users indicate the potential for widespread secondary transmission of HIV • This risk taking may be connected w/ cocaine injection and smoking (this should be further expired) • Further research is required on ways to overcome barriers to condom use and to reach heterosexual identified male IDUs engaged in sexual activity with males • Sexual risk reduction strategies are needed for this population	• Non-random sample • Lack of information on duration of partner relationships • Bias in recalling and accurately portraying past sexual activity

POPULATIONS IN DRUG TREATMENT (NON-IDU)

Published Behavioral Studies:

1. HIV Infection and Risk Behaviors Among Heterosexuals in Alcohol Treatment Programs.
Avins AL, Woods WJ, Cindan CP, Hudes ES, Clark W, Hulley SF
JAMA, February 1994; 271(7): 515-518

2. Correlates of Sexual Risk-Taking Among Gay Male Substance
Paul JP, Stall RD, Crosby GM, Barrett DC, Midanik LT
Addiction, 1994; 98:971-983

3. Sexual Risk for HIV Transmission Among Gay/Bisexual Men in Substance-Abuse Treatment.
Paul JP, Stall RD, Crosby GM, Davis F
AIDS Education and Prevention, 1993; 5(1): 11-24

POPULATIONS IN DRUG TREATMENT (NON-IDUS)

Behavioral Summary

Initial research indicates that populations in drug treatment programs may be at increased risk for HIV infection. Two studies of populations in treatment programs (one with gay/bisexual men and one with heterosexual men and women) found higher rates of HIV infection and risky sexual behavior than comparable population based studies.

Comparing the results of one study of sexually active gay and bisexual men entering a substance abuse treatment center to results from the San Francisco Men's Health Study cohort, the relative risk of engaging in unprotected anal intercourse was greater for the substance abuse treatment sample. Sixty seven percent of this sample reported always being high on alcohol or drugs when having anal sex without condoms (speed use was particularly associated with unsafe sex). For men in this study, unprotected anal sex with primary partners appeared to be influenced more by relationship factors, but with non-primary partners substance use variables seem more important.

A recent study of heterosexuals in alcohol treatment programs found seroprevalence rates that were much higher than those found in a random household probability sample of heterosexuals in the communities where the treatment population predominantly lived (the AMEN study). Why the rates of infection are elevated in this population is unclear, but the probable mode of transmission appears to be heterosexual contact. Only 3% of this population reported consistent condom use and many reported always combining alcohol and/or drug use with sexual activity. In addition, 26% of those without a history of injection drug use reported having sex with an IDU.

Recommendations for Prevention

There is a need for HIV primary prevention programs within substance abuse treatment agencies. Because these agencies are a point of entry and way of reaching individuals who may be at high risk for HIV infection, training staff in HIV prevention is critical. Interventions should help patients develop skills for having and maintaining sober sex since relapse of one behavior may mean relapse in another.

Many substance users are not in treatment, so street based interventions for reaching other substance using populations should be developed and

evaluated. Surveys in STD clinics, schools and primary care facilities have shown that the combination of alcohol drugs with sexual activity is a very common practice. All HIV prevention programs should explore the relationship of alcohol and drug use and sexual behaviors in their target populations. Good interagency referral between HIV prevention programs and alcohol/drug prevention and treatment programs is critical.

Recommendations for Future Research

Future research should look at substance using populations who are not in treatment. Homeless and mentally disabled, out of treatment populations may be of particular interest. Studies of gay men in drug treatment programs should involve larger samples of minority populations and should explore possible differences between gay and bisexual men. Future research should also focus on in-treatment and out-of-treatment youth populations. Alcohol and drug use questions should be included in future KABBs and needs assessments.

HIV Infection and Risk Behaviors Among Heterosexuals in Alcohol Treatment Programs
Avins AL, Woods WJ, Lindan CP, Hudes ES, Clark W, Hulley SB
JAMA, February 1994; 271(7):515-518

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross sectional interview survey and seroprevalence screening • Oct. 1990 -Dec. 1991 888 heterosexual clients from alcohol treatment programs consecutively sampled • Treatment centers with many minority clients were chosen • Response rates were 80% for residential centers and 53% for outpatient sites • Compared with non-respondents, respondents were more likely to be male, to be less than 40 yrs old, to be white and not to be Latino • 64 males w/ gay history in past year excluded	• 76% male • 53% Afr-Amer • 11% Latino • 36% White • 32% <= 30 yrs • 43% 31-40 yrs • 21% >= 40 yrs • 5% tested positive for HIV • 38% of those infected denied any IDU, male homosexual activity, or a history of transfusions • History of syphilis was related to HIV positive • 67% unemployed • 26% homeless	• 45% of those sexually active had at least three partners past year • 24% used alcohol and 18% used other drugs every time before having sex w/ primary partner • 56% used alcohol and 45% used other drugs every time before having sex w/ secondary partner • 71% did not use condoms when having sex w/ main partners • 43% of those w/ a secondary partner never used condoms • Only 3% reported consistent condom use	• 41% had a history of IV drug use & 80% reported sharing their injection equipment at some point • 88% of those who had ever injected reported IV drug use in past year • 26% of those reporting a history of IDU reported having sex in past year with someone they believed had never injected drugs • 26% of those with out a history of IDU reported having sex w/ IDU	Predictors of HIV infection using multiple logistic regression: • History of IDU • History of syphilis	• The rate of infection among respondents who reported neither homosexual male sex nor needle use was much higher than expected • The rates shown in this study are much higher than those found in a random household probability sample of heterosexuals in SF in the communities where treatment participants lived: among women who are not IDUs (4% vs.. .2%); and among men who are not IDUs and do not engage in sex with men (3% vs.. .5%) • Why rates of infection are elevated in this population is unclear, but probable mode of transmission appears to be heterosexual contact.	• Data may not be generalizable to alcoholics who do not seek treatment or to other treatment settings • Risk factor data collected by self report may not be entirely reliable • Sexual behaviors of women having sex with women were not mentioned • Underrepresented Latinos, women and older clients

Correlates of Sexual Risk-Taking Among Gay Male Substance Users
Paul JP, Stall RD, Crosby GM, Barrett DC, Midanik LT
Addiction, 1994; 98: 971-983

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross sectional, interview administer survey • 1988-1989 • 383 sexually active gay and bisexual men entering substance abuse treatment consecutively sampled	• 9% African-Amer • 4% Latino • 78% White • 9% other • Mean age = 35 (28% were under 30 yrs of age) • 38% unemployed	• 55% of sexually active men engaged in anal intercourse without a condom w/in past 90 days • 38% had a male primary partner • 30% reported unprotected anal intercourse with ejaculation • 26% reported unprotected anal w/ withdrawal • Of the 212 who had anal intercourse w/ out a condom, 77% did so w/ a non-primary partner. • Of the 42 men who had unprotected anal sex w/ a primary partner only, 67% were not in a mutually monogamous relationship	• 56% reported injection drug use in past year • 65% identified as alcoholic • 72% identified as drug abusers or addicts • 43% identified as both alcoholic and addict		• These finding show that substance abusing gay and bisexual men are a population at great risk for sexual transmission of HIV • Unprotected anal sex with primary partners may be influenced more by relationship factors than situation factors, but with nonprimary partners substance use variables seem more important • A high proportion of risk taking appeared to be agreed upon as long as withdrawal was used • High risk sex was frequently reported as resulting when the participants were too "turned on" sexually to stop • Risk reduction programs should focus on developing health-promoting social support	• Small sample size • Sampled population was mostly White • Bisexual and gay men were combined even though their behaviors may be different • Sexual behaviors with women not measured

Sexual Risk For HIV Transmission Among Gay/Bisexual Men in Substance-Abuse Treatment
Paul JP, Stall RD, Crosby GM, Davis F
AIDS Education and Prevention, 1993; 5(1): 11-24

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross sectional, anonymous questionnaire (CAQ) • May 1988 - Oct 1989 • 314 sexually active gay and bisexual men entering substance abuse treatment. recruited at 18th Street Services • Response rate = 80% • Results were compared to the San Francisco Men's Health Study cohort which was recruited by multistage probability sampling in 1984. • This cohort drew from the same geographical are served by 18th street services & was comparable on a number of demographic variables	• Both samples were predominantly white and well educated, and the vast majority were in their thirties • About 75% of the CAQ were knew their serostatus (58% were HIV positive)	• The relative risk of engaging in high risk sexual behaviors was consistently greater for the substance abuse treatment sample, with the highest relative risk being for unprotected receptive anal sex • Sexual behaviors for the treatment program vs.. SFMHS: • Unprotected insertive anal sex (21% vs.. 17%) • Unprotected receptive anal sex (23% vs.. 15%) • Unprotected insertive and/or receptive anal sex (32% vs.. 22%)	• 63% identified as alcoholics or alcohol abusers • 38% had amphetamine addiction/abuse • 27% had marijuana abuse • 20% had cocaine addiction/abuse • Only 69 of the 314 treatment survey respondents reported IV drug use in the past 90 days (primarily speed) and only 29 (42%) reported sharing and of those, only 8 reported some risk due to not always cleaning needles before sharing	Treatment sample: • 67% reported always being high on alcohol or drugs when they had anal sex without condoms • 69% combined speed was the drug most frequently combined with sex & was associated w/ unsafe • Those who reported a history of IV drug use were more likely to report having engaged in unprotected anal sex in past 90 days • Those who reported speed use as a presenting problem at intake were more likely to have unsafe sex w/ a nonprimary partner in the past 90 days	• The sample of gay and bisexual men in substance abuse treatment reported significantly higher levels of unprotected anal intercourse than did the sample for SFMHS cohort. • Despite the overall dramatic reductions in sexual risk behaviors in the gay/bisexual community, this subpopulation of men continue to be at great risk for HIV transmission • This study emphasizes the need for AIDS primary prevention programs within substance abuse treatment agencies • To lessen the likelihood of alcohol or drug use when in sexual situations, many gay and bisexual men in treatment may need help in learning to have "sober sex"	• Drug treatment group were somewhat younger and less well educated • Data collection procedures differed • Sampled populations were mostly White and highly educated, so it is unclear whether results are generalizable for minority or less educated • Bisexual and gay men were combined even though their behaviors may be different • Sexual behaviors with women not measured

POPULATIONS WHO USE CRACK

Published Behavioral Studies:

1. HIV Risk-Related Sex Behaviors Among Injection Drug Users, Crack Smokers, and Injection Drug Users Who Smoke Crack.
Booth RE, Watters JK, Chitwood DD
American Journal of Public Health, August 1993; 83(8): 1144-1148

2. Crack Cocaine and the Exchange of Sex for Money or Drugs
Risk Factors for Gonorrhea Among Black Adolescents in San Francisco
Schwarcz SK, Bolan GA, Fullilove M, McCright J, Fullilove R, Kohn R, Rolfs R
Sexually Transmitted Diseases, January-February 1992; 19(1): 7-13

3. High-Risk Behavior Among Young Street-Recruited Crack Cocaine Smokers in Three American Cities: An Interim Report.
Edlin BR, Irwin KL, Kudwig DD, McCoy HV et al.
Journal of Psychoactive Drugs, Oct-Dec 1992; 24(4): 363-370

POPULATIONS WHO USE CRACK

Behavioral Summary

Several studies have shown that populations that use crack may be at increased risk for HIV infection. Not only is crack use an added risk factor for IDUs, it appears to be associated with increased risk of STD infection (including HIV) among non-IDUs. Crack users have been found to engage in higher risk sexual behaviors such as exchanging money or drugs for sex and having multiple partners. The dramatic increase in gonorrhea and syphilis among African Americans in 1988 and 1989 paralleled the crack epidemic in African American communities. Despite variation in study design and measurement, most research has found the exchange of sex for money or drugs to be an important link between crack use and STD infection in female adolescents.

Although STD rates have been declining steadily since 1989, crack cocaine users are still at risk for infection (particularly young African American women). The most recent sampling of young crack smokers in the Bay View Hunters Point area found that female smokers engage in more high risk sexual behaviors than male smokers. This same study found that few crack smokers had been in treatment, but about a third had been incarcerated and 73% visited an Emergency Room or medical clinic in the past year.

Recommendations For Prevention

Preventing the spread of HIV in communities where the epidemics of crack cocaine use and HIV intersect, will require efforts directed both at crack use and the associated sex practices. STD clinics, teen clinics, Emergency Rooms and incarceration facilities may be important venues for reaching crack using youth. However, street outreach and mobile vans should also try to reach those who never access any services. Creative methods of changing sexual behavior and encouraging condom use among crack users and their partners need to be developed and evaluated.

Other approaches should be employed to address crack use itself, including culturally appropriate and youth specific drug treatment programs and positive community building designed to change community norms and prevent initiation of drug use and encourage safe sex among users. Finally, treatment of STDs will help prevent further STD and HIV transmission. If clinics are not being used, treatment and education that is taken into the community using mobile vans may be more effective.

Recommendations for Future Research

Because crack use appears to mediate high-risk sexual behaviors, targeted surveillance of drug use and associated sexual behavior should be expanded in areas where STDs are more prevalent. Future studies should use uninfected and/or non-using comparison groups and should have larger sample sizes to provide more accuracy. Gender, age, and racial/ethnic differences should be further explored. Initial research has illuminated gender differences that warrant specific intervention and evaluation research for young women.

HIV Risk-Related Sex Behaviors Among Injection Drug Users, Crack Smokers, and Injection Drug Users Who Smoke Crack
Booth RE, Watters JK, Chitwood DD
American Journal of Public Health, August 1993; 83(8):1144-1148

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross sectional, multi-site study of drug users recruited in San Francisco (87), Denver (83), and Miami (76) • During May and June of 1991 • Sampling conducted in inner city neighborhoods that had a high degree of injection drug use • Recruitment was directed to cut across social circles of drug users • Eligibility criteria included being at least 18 years old, not intoxicated, self-reported IDU in past 30 days and/or use of crack in past 2 days (verified by visual exam & urinalysis for crack)	• Crack smokers were younger, less likely to be married • Injectors were more likely to be Latino • Male: 67 % of injectors, 61% of smokers and 69% of smoking injectors • African American: 34% of injectors, 76% of smokers and 69% of smoking injectors • Latino: 42% of injectors, 13% of smokers, and 11% of smoking injectors • White: 24% of injectors, 11% of smokers, 11% of smoking injectors • Over 50% of all groups were unemployed	• 71% had sex in past 30 days • Mean number of sexual partners was 6 • 44% reported multiple partners • Women averaged more sex partners than men (11.5 vs.. 3.3) • Crack smokers and smoking injectors were more likely than injectors to report they had two or more sex partners in past month • 52% of female smokers reported multiple sex partners • Smokers were less likely to have sex with a partner who was known to be an IDU • Smoking injectors were more likely to have an IDU partner • Smokers and smoking injectors were more likely to report having sex without condoms smokers and smoking injectors were also more likely to exchange drugs for sex or money	• 81 IDUs • 57 smokers • 108 smoking injectors • Smokers and smoking injectors were more likely to use drugs during sex than injectors	• Overall, higher frequency of drug use was associated with more high risk behaviors such as multiple partners, unprotected sex, sex w/ an IDU, exchanging sex for $ or drugs • Crack use (particularly among those who also injected) was associated with an increase in high risk sexual behaviors • Crack smokers and crack smoking injectors were more likely to have a history of STD • Smoking injectors were more likely than the other two groups to report frequent drug use and drug use in association w/ high risk sexual behavior • Use of crack among IDUs may increase the potential risk of infection	• Crack smoking injectors were more likely to report sex with an injector, exchanging sex for drugs and/or money, drug use before or during sex, and unprotected sex • Crack smoking injectors also injected more than injectors only, smoked crack as often as smokers only and reported higher overall frequencies of drug use • These findings, together w/ higher rates of STDs reported by smokers and smoking injectors are indicators of the risk that crack poses for heterosexual transmission of HIV	• Possible confounder is combining city sites, but controlling for location, drug group differences were in the same direction and statistically significant • Non-random sample, can not generalize finding to all drug users

Crack Cocaine and the Exchange of Sex for Money or Drugs
Risk Factors for Gonorrhea Among Black Adolescents in San Francisco
Schwarcz SK, Bolan GA, Fullilove M, McCright J, Fullilove R, Kohn R, Rolfs RT
Sexually Transmitted Diseases, January February 1992; 19(1):7-13

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Case control study • 68 African American adolescents diagnosed with gonorrhea were compared to 136 control subjects from the same community (the five high prevalence neighborhoods) • All had to be 15-19 years old • Response rates: 78% for cases 74% for controls	• About half of all subjects lived with only one parent • All were heterosexual • Mean age = 17	Females: • 31% of the gonorrhea patients reported receiving money or drugs for sex, but none of the controls reported this behavior • Mean number of partners among patients was significantly higher than among control subjects Males: • The differences between patients and controls observed for females was not apparent for males	Females: • Crack cocaine use was reported more often by gonorrhea patients than control subjects • Alcohol and marijuana use in the past month was reported more often by patients than control subjects • Crack use was reported by 89% (8/9) patients who received money or drugs for sex, compared with 11% (2/19) patients and 6% (4/65) of control subjects who denied receiving money or drugs 4 sex		• The exchange of sex for money or drugs is an important risk factor for gonorrhea among African American female adolescents in SF • Crack appears to be related to gonorrhea through its association w/ exchanging $/drugs 4 sex • This relationship did not appear for young men • Future studies should look at whether high risk sexual behaviors take place in crack houses (which might increases the chance of exposure) • The association between substance use and high risk sexual behavior suggests a need to link substance abuse and STD treatment & prevention efforts	• Non-random sample • Small sample size • Case control study

High-Risk Sex Behavior Among Young Street-Recruited Crack Cocaine Smokers in Three American Cities: An Interim Report
Edlin BR, Irwin KL, Ludwig DD, McCoy HV et al
Journal of Psychoactive Drugs, Oct-Dec 1992; 24(4):363-370

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Conclusions / Recommendations	Comments / Limitations
• Cross sectional interview survey of youth in urban neighborhoods in SF(BVHP), New York and Miami • Results from 1991 • Eligible participants were 19 to 20 yeas old and either current regular smokers (smoked in past 30 days) or nonsmokers of crack (never used). Smokers and nonsmokers were further stratified for IDU • In 1991, 1,356 were sampled (6300 crack smokers/ no IDU; 516 non smokers/ no IDU; 144 smokers / IDU and 66 non smokers / no IDU)	• 56% men • 78% Afr-Amer. • 18% Latino • 76% single • 23% lived on streets or in shelters • 49% had less than high school education • 23% received public assistance • 26% derived most of their income from illegal activities including prostitution • 31% had been incarcerated in past year • Only 16% had been in substance abuse treatment during that year, but 73% had visited a medical clinic or ER	• The crack smokers in this sample engaged in higher risk sex behaviors than the nonsmokers. This differences was particularly evident among the participants who had never injected drugs. • Crack smokers where more likely than nonsmokers to report exchanging sex for $ or drugs, having had more sex partners and ever having a STD. • Less than one third used condoms consistently and less than half of the sample used a condom when they last had sex. • Condom use was generally infrequent, regardless of sex or drug use history,	• 85% had never injected	• The crack users engaged in higher risk sexual behaviors than nonsmokers (sex for $/drugs, multiple partners, history of STD, sex w/ IDU etc.) This difference was particularly evident among the participants who had never injected drugs • Female crack smokers engage in more high risk behaviors than male crack smokers	• Education and prevention programs are needed to reach crack smokers (especially females) • Preventing the spread of HIV in inner-city communities, where the epidemics of HIV and crack cocaine use intersect, will require efforts directed both at crack use and at the associated sex practices. • A large majority of subjects had been to a clinic or hospital ER room in the past year and various numbers had completed high school, had received public assistance and had been in jail. These institutions may be important venues and opportunities for reaching these youth (especially health care facilities) • Because most subjects had never been in treatment, programs specifically targeting out of treatment youth are needed	• While street recruitment provides a method of sampling persons who may be missed by other methods, it is neither random nor population based. Street recruitment oversamples visible groups, but hidden users are undersampled

GAY/BISEXUAL MEN WHO USE POPPERS

Published Behavioral Studies:

1. Recreational Drugs and Sexual Behavior in the Chicago MACS/CCS Cohort of Homosexually Active Men.
   Ostrow DG, Beltran ED, Josepha JG, DiFrancesco W, Wesch J, Chimiel JS
   Journal of Substance Abuse, 1994; 5(4); 311-325

2. Predictors of Lapse to Unprotected Receptive Anal Intercourse in a Cohort of Homosexual and Bisexual Men in the USA.
   Valleroy L, Rolfs R, Schnell D, O'Reilly K
   Poster presented at the 9th International Conference on AIDS, 1993

3. HIV Seroprevalence and Risk Behaviors Among Young Men Who Have Sex With Men. San Francisco/Berkeley, California, 1992-1993.
   Lemp G, Hirozawa A, Givertz D
   San Francisco Dept. of Public Health; Berkeley Dept. of Health & Human Services

GAY/BISEXUAL MEN WHO USE POPPERS

Behavioral Summary

Although none of the San Francisco cohort studies of men who have sex with men have looked closely at popper use, a large cohort study in Chicago found that men who combined poppers with other drugs were at highest risk both behaviorally and in terms of HIV seroconversion throughout the study. Popper use was also associated independently with lapse from safer sexual behaviors (failure to use a condom during receptive anal sex) among non-monogamous men.

Another multi-site study in Dallas, Denver, Long Beach and Seattle found use of poppers and being 20-24 years old were the only factors that predicted increased risk of lapse in a multivariate logistic model. Locally, the Young Men's Survey (gay and bisexual men between the ages of 17 and 22) found that being high on poppers during sex the last six months was a significant risk factor for unprotected anal intercourse.

Recommendations for Prevention

Gay and bisexual men who use poppers may be at risk for unprotected anal intercourse and relapse. Behavioral intervention programs that target the combination of recreational drug use and sexual relapse among men who have sex with men are urgently needed. Interventions for men who have sex with men should focus not only on initial behavior change, but also on the likelihood of lapse and the maintenance of behavior change.

Recommendations for Future Research

Future research should assess the amount of popper use that is going on in the gay and bisexual communities and the social context of use with different populations such as young men. Interventions for men who use poppers should be designed and evaluated, noting whether stopping popper use is related to improvement in risk taking sexual behavior.

Recreational Drugs and Sexual Behavior in the Chicago MACS/CCS Cohort of Homosexually Active Men
Ostrow DG, Beltran ED, Josepha JG, DiFrancesco W, Wesch J, Chmiel JS
Journal of Substance Abuse, 1994; 5(4):311-325

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cohort study of gay men who participate in the Chicago MACS study • Men are recruited from either a community-based STD clinic or the infectious disease program of Northwestern University • Take home survey which men return by mail 2 weeks following their baseline assessment • Of the 1,005 who participated, only 384 completed all surveys & assessment visits • There were no statistically significant differences between those participants and non-participants	** Not listed	** See predictors	• Overall, a pattern of decreasing drug use over 6 years was observed that paralleled a decline in high risk sexual behavior • Alcohol remained stable & was not associated with sexual behavior change • Men who combined poppers with other drugs were at highest risk both behaviorally and in terms of HIV seroconversion throughout the study	• Popper use was also associated independently with lapse from safer sexual behaviors (failure to use a condom during receptive anal sex) • Controlling for type of relationship, popper use was only associated w/ unsafe sex for non monogamous men • Stopping popper use was unrelated to improvement in safer sex	• Gay men who use poppers may be at risk for relapse • The prevention messages for men who may be using poppers and having unsafe sex are complex • Equating popper use w/ unsafe sex may be too simplistic, but saying substance use can "make them unsafe" , gives people an excuse for taking personal responsibility • Behavioral intervention programs that are targeted at the combination of recreational drug use and sexual relapse among homosexual/ bisexual men and increasing self-control over both types of behavior are urgently needed	• High attribution • Non-random sample limits generalizability • Need to be careful generalizing from MACS cohort to broader population of gay men

Predictors of Lapse to Unprotected Receptive Anal Intercourse in a Cohort of Homosexual and Bisexual Men in the USA
Valleroy L, Rolfs R, Schnell D, O'Reilly K
Poster presented at the 9th International Conference on AIDS, Berlin Germany 1993

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cohort of homosexual and bisexual men (CDC's AIDS Community Demonstration Project) • Sites = Dallas, Denver, Long Beach & Seattle • Men came for a visit every 6 months where they received HIV counseling & testing, HIV behavioral interventions, self-administered surveys • The analyses focus on 1,006 seronegative men w/ complete data on anal intercourse for visits 1 and 2	• 1,006 seronegative gay or bisexual men	• Of the 715 men who did not have unprotected receptive anal intercourse in the 3 months before visit 1, 81% did no lapse into URAI in the 3 months before visit 2, • 19% lapsed into URAI		• Behaviors that predicted relapse when entered as independent variables in a multiple logistic model: • Use of poppers and being 20-24 years old were the only factors that were associated w/ increased risk of lapse	• Lapse was frequent and predictors of lapse were younger age (20-24) and use of poppers • HIV/AIDS interventions for homosexual and bisexual men should focus not only on initial behavior change, but also on the likelihood of lapse and the maintenance of behavior change	• Self reported data on sensitive behaviors • May not be generalizable because men in the cohort were men who attended an HIV behavioral intervention study for at least two visits

HIV Seroprevalence and Risk Behaviors Among Young Men Who Have Sex With Men
San Francisco/Berkeley, California, 1992-1993
Lemp G, Hirozawa A, Givertz D et al.
SF Dept. of Public Health, San Francisco; Berkeley Dept. of Health and Human Services, Berkeley

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross sectional survey of young men recruited from street sites, dance clubs, bars, sex clubs and parks identified in focus groups as sites (26) frequented by young men who have sex w/ men (n=425) • Random sampling based on proportion of persons frequenting a setting in a given week • Interviews were conducted and blood was drawn in vans • 1992 - 1993 • Response rate = 61%	• Age range of 17-22 (study is discussed in the young gay men behavioral & prevalence section)			• Being high on poppers during sex in the last 6 months was a significant risk factor for unprotected anal intercourse (60% Vs.. 32%); adjusted OR=3.0; 95% CI 1.4-6.8)		• Recruitment from bars, clubs etc. limits generalizability • Does not report differences in seroprevalence among those who use poppers

YOUNG GAY AND BISEXUAL MEN

Published Behavioral Studies:

1. Human Immunodeficiency Virus Infection in Homosexual/Bisexual Men, Ages 18-29: The San Francisco Young Men's Health Study.
   Dennis H. Osmond, PhD; Kimberly Page, MPH; James Wiley, PhD; Karen Garrett, MA; Haynes W. Sheppard, PhD; Andrew R. Moss, PhD; Lewis Schrager, MD; Warren Winkelstein, MD
   - unpublished results

2. HIV-1 Seroprevalence and Risk Behaviors Among Young Men Who Have Sex With Men.
   George Lemp, Anne Hirozawa, Daniel Givertz, Giuliano Nieri, Jason Bishop, Vincent Fuqua, Mario Hernandez, Luiz Goni, Welmin Militante, Elliot Ramos, Sean Nguyen, Melissa Jones, Laura Anderson, Robert Janssen, Mary Lou Lindegren, and Mitchell Katz.
   San Francisco Dept. of Public Health, San Francisco, CA, Berkeley Dept. of Health and Human Services, Berkeley, CA, Division of HIV/AIDS, Centers for Disease Control, Atlanta.

3. Seroprevalence of HIV and Risk Behaviors Among Young Homosexual and Bisexual Men.
   The San Francisco/Berkeley Young Men's Survey
   George F. Lemp, DrPH; Anne M. Hirozawa, MPH; Daniel Givertz; Giuliano N. Nieri; Laura Anderson, MPH; Mary Lou Lindegren, MD; Robert S. Janssen, MD; Mitchell Katz, MD.
   JAMA, August 10, 1994; 272(6):449-454

YOUNG GAY AND BISEXUAL MEN

Behavioral Summary

Young gay and bisexual men continue to engage in high-risk behaviors, particularly unprotected anal intercourse, and as a result, could approach seroconversion rates first experienced by gay and bisexual men in the early years of the epidemic. Clearly, HIV/AIDS prevention programs have not kept pace with the changing needs of the population of young gay and bisexual men in San Francisco. While impressive success has been achieved with older gay and bisexual men due to intensive prevention programs in the early 1980's, the same intensity of programming and outreach has been seriously lacking for younger gay and bisexual men.

One study of young gay and bisexual men found that the number of sexual partners, number of receptive anal intercourse partners, injection drug use, age and race were significant predictors of seropositivity. Of particular interest in this study was the finding that knowing their primary partner's HIV status did not appear to be a factor in reducing high risk sexual behaviors. This may be explained by the finding that the strongest barrier to practicing safe sex among this particular sample may exist in close relationships where issues of intimacy, trust, and sharing risk work against safe behaviors.

Recommendations for Prevention

A significant finding of the Young Gay Men's Health Study is that typically, unsafe sex seems to occur within one's own home or one's partner's home. Contrasting the popular myth that bathhouses and sex clubs foster unsafe behavior, this finding suggests the need for prevention messages that are personalized to type of relationship (in this study 44% of the sample reported a steady partner vs. 28% reporting a casual partner) and again, to issues of trust and intimacy.

It has not been a common finding that younger gay and bisexual men are unaware of behaviors that place them at risk for infection. Targeted prevention programs must begin to address changing peer norms for safe sex, providing HIV counseling and testing services for this specific population, and the psychosocial needs of young gay and bisexual men, including support and counseling to address issues of abuse and forced sex, and programs to develop and improve communication/negotiation skills, and programs to address substance abuse.

Recommendations for Future Research

These studies consistently associate African American race with the highest rates of seroconversion among young gay and bisexual men. However, there is little understanding of the factors and determinants that are causing this serious trend. Research that is focused on HIV prevention strategies within communities of color and the effects of culture, values, and beliefs across cultural boundaries must be thoroughly explored for the design and implementation of effective prevention programs for young and bisexual men of color.

Human Immunodeficiency Virus Infection in Homosexual/Bisexual Men, Ages 18-29: The San Francisco Young Men's Health Study.
Dennis H. Osmond, PhD; Kimberly Page, MPH; James Wiley, PhD; Karen Garrett, MA; Haynes W. Sheppard, PhD; Andrew R. Moss, PhD; Lewis Schrager, MD; Warren Winkelstein, MD

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• A multistage probability sample was drawn of households from the 21 census tracts in San Francisco with the highest cumulative incidence of AIDS and screened for homosexual men ages 18 through 29 to participate in an interview and HIV testing. • Baseline survey began in March 1992 and completed in April 1993. • 1,387 eligible; 1076 completed the interview (77.6%) • Eligibility criteria: sexual intercourse with a man in the past five years or self-identification as homosexual/ bisexual		• 63% reported at least one receptive anal intercourse partner in the past 12 months, and 38% two or more. • 59% of those with at least one RAI partner reported using condoms all the time, 21.3% most of the time, 6.0% some of the time, 12.7% none of the time. (lower seroprevalence in group reporting using condoms all the time) • <u>Venues Where Unsafe Anal Sex Occurs:</u> Partner's Home: 60.4% Own home: 48.9% Hotel: 18.7% Car: 10.8% Beach: 10.1% Park: 9.4% Bathhouse: 3.6% Bar: 3.6% Sex Club: 2.9% Bookstore: 2.2% Bathroom: 1.4% • <u>Partner Type:</u> Casual: 28% Steady: 44% Both: 28%	• 10.2% reported a history of injection drug use. (36.4% HIV+) • 61.4% reported having shared injection equipment. (40.7% HIV+) • Using injection drugs by age: 18-23: 12% 24-26: 8% 27-29: 11.5% • Subjects reporting IDU did not report more high risk sexual behavior.	• HIV seropositivity was associated with: • The number of sexual intercourse partners in the past 12 months. • Number of receptive anal intercourse partners in past 12 months. • Injection drug use • Age • Race • Education • Year of first regular sexual intercourse w/men • Knowing their primary partner's HIV status did not appear to be a factor in reducing high risk sexual behavior.	• Some of the strongest barriers to practicing safe sex may exist in close relationships where issues of intimacy, trust, and sharing risk may work against safe behaviors. • High-risk behavior was reported by the majority of the sample.	• Area of the survey captures only a portion of homosexual men living in San Francisco.

HIV-1 Seroprevalence and Risk Behaviors Among Young Men Who Have Sex With Men.
George Lemp, Anne Hirozawa, Daniel Givertz, Giuliano Nieri, Jason Bishop, Vincent Fuqua, Mario Hernandez, Luiz Goni, Welmin Militante, Elliot Ramos, Sean Nguyen, Melissa Jones, Laura Anderson, Robert Janssen, Mary Lou Lindegren, and Mitchell Katz.
San Francisco Dept. of Public Health, San Francisco, CA, Berkeley Dept. of Health and Human Services, Berkeley, CA, Division of HIV/AIDS, Centers for Disease Control, Atlanta.

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• Surveyed 474 men 17 to 22 yrs at 26 locations in SF and Berkeley during 1992 and 1993 • Survey sites: street, dance clubs/bars, sex clubs, parks where young men have sex w/men. • 61% of 778 eligible persons approached agreed to participate in the survey. • A trained interviewer conducted a structured face-to-face interview using a standardized 87-item questionnaire. • Specimens were tested for HIV-1, present and past syphilis infection, and markers of Hep. B • The analyses were limited to 425 men who reported sex w/men or who self-identified as gay or bisexual	• Age: 20-22 yrs.: 71.3% 17-19 yrs.: 28.7% • Race/Ethnicity: Other: 1.9% Native American: 2.8% Asian: 11.3% African American: 12.2% Latino: 22.4% White: 49.4%	• Prevalence of Unprotected Anal Intercourse in Previous Six Months by • Age: 17-19: 28.7% 20-22: 34.3% • Race/Ethnicity: White: 28.1% African American: 38.5% Latino: 40.0% Asian/PI: 27.1% Other: 45.0% • History of Forced Sex: No: 26.7% Yes: 41.4% • Knowledge of HIV Status: HIV +/know: 33.3% HIV +/don't know: 35.7% HIV -/know: 30.2% HIV-/don't know: 33.3% • Peer Norms Regarding Safe Sex: Positive: 23.2% Negative: 45.7% • Know Someone w/AIDS: Yes: 32.1% No: 35.4%	Prevalence of Unprotected Anal Intercourse in Previous Six Months: • High on Poppers: No: 31.8% Yes: 60.0% • High on Alcohol: No: 27.8% Yes: 39.4% • Prevalence of Injection Drug Use: Over Lifetime: 16.6% Last 6 mos.: 11.8%			

Seroprevalence of HIV and Risk Behaviors Among Young Homosexual and Bisexual Men. The San Francisco/Berkeley Young Men's Survey
George F. Lemp, DrPH; Anne M. Hirozawa, MPH; Daniel Givertz; Giuliano N. Nieri; Laura Anderson, MPH; Mary Lou Lindegren, MD; Robert S. Janssen, MD; Mitchell Katz, MD.
JAMA, August 10, 1994; (272)6

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• A survey of 425 young homosexual and bisexual men sampled from 26 locations during 1992 and 1993. • Participants were interviewed and blood specimens were drawn and tested for HIV, level of $CD4^+$ T lymphocytes, and markers of hepatitis B and syphilis.	• Age Range (%): 17 - 19 yrs (29) 20 - 22 yrs (71) • Race/Ethnicity (%) White (49) Latino (22) African American (12) A/PI (11) Native American (3) Other (3)	• Unprotected anal intercourse previous six months (%) (32.7% of sample) • /steady partners (44) • w/casual partners (28) • w/both (28)	• Prevalence of unprotected anal intercourse significantly higher among men who reported using nitrites or alcohol during sex. • No significant association between unprotected anal intercourse and using other substances during sex. • 17% reported injecting drug use at some time in their lives. • Of these, 14% had shared needles or works that had not been cleaned w/bleach or alcohol in the previous six months. • IDU by race/ethnicity (%): Native Americans (25) Whites (15.8) Other races (12.5) African Americans (9.6) Latinos (8.4) A/PI (0) (Age not significant)	• Predictors of HIV Infection: (Among men who have had anal sex w/other men) • Lifetime history of STDs • Lifetime # of male sexual partners • African-American race • Greater age • History of IDU • Predictors of unprotected anal intercourse: • Negative peer norms regarding safe sex • Being under the influence of nitrites during sex • Lifetime history of forced sex • Under the influence of alcohol during sex	• More emphasis should be placed on changing peer norms for safe sex, on providing targeted HIV counseling and testing services, and on addressing the psychosocial needs of young homosexual and bisexual men, including support and counseling to address issues of abuse and forced sex, programs to develop and improve communication/negotiation skills, and programs to address substance use, particularly with regard to the abuse of nitrites and alcohol.	• Limited to young men who attended any one of 26 venues in San Francisco and Berkeley. • Only 61% of eligible men agreed to participate.

IN - SCHOOL YOUTH

Published Behavioral Studies:

1. Comparison of AIDS Knowledge & HIV-Related Behaviors Among Adolescents in Low & High AIDS Prevalence Communities.
   DiClemente RJ, Brown LK
   Journal of Adolescent Health; 1993; 14:231-236

2. HIV Knowledge Communication and Risk Behaviors Among White, Chinese-Filipino-American Adolescents in a High Prevalence AIDS Epicenter: A Comparative Analysis.
   Ethnicity & Disease, 1993; 3:97-105

3. Determinants of Condom Use Among Junior High School Students in a Minority, Inner-City School District.
   Pediatrics, February 1993; 89(2): 197-202

4. Factors Associated With Multiple Sexual Partners Among Junior High School Students.
   Durbin M, DiClemente RJ, Diegal D, Kransnovsky F, Lazarus N, Camacho T
   Journal of Adolescent Health, 1993; 14:202-207

5. Health Risk Behaviors and Health Concerns Among Young Adolescents.
   Millstein SG, Irwin CE, Adler NE, Cohn L, Kegeles SM, Dolcini MM
   Pediatrics, March 1992; 3:422-428

6. Psychosocial and Behavioral Factors Associated with Risk of STDs, Including HIV Among Urban High School Students.
   Shafer MA, Boyer CB
   Journal of Pediatrics, November 1991; 826-833

KABB Behavioral Summaries:

7. High School Youth Behavior Risk Survey
   San Francisco Unified School District, 1993

8. High School Youth Behavior Risk Survey; 1993
   (Comparison of comprehensive high schools with the small, necessary high schools)

IN-SCHOOL YOUTH

Behavioral Summary

During adolescence many teenagers initiate sexual intercourse and experiment with alcohol and drugs. Such activities can be viewed as a normal part of adolescent development, but sexual and drug using behaviors are influenced by peer pressure a sense of invulnerability and may put adolescents at increased risk for HIV infection.

Studies of high school youth in San Francisco generally find that at least a third are sexually active and about 20% reported their sexual debut at 12 years old or younger. Youth attending small, but necessary high schools (which include alternative and community day schools) are more likely to be sexually active (62%) and Chinese students are less likely to be sexually active (13%). About 20% of middle school youth are sexually active and over half of them reported their sexual debut at 12 years or younger.

Infrequent condom use is common among sexually active in school youth. The 1993 Youth Risk Behavior Survey (YRBS) found that 40% of all high school students did not use a condom the last time they had sex. The time frame for looking at multiple partners varied between studies, but among sexually active youth this was a common experience. The YRBS found that about 30% had two or more partners in the past 3 months.

About two thirds of high school and middle school students report alcohol use, 20%-30% use marijuana, and about 5% use some form of cocaine. Combining alcohol and drug use with sex was common and in one study alcohol and drug use was the best predictor of sexual risk behavior. The YRBS found that 20% of all high school students were high the last time they had sex. Injection drug use is relatively low among high school and middle school students (around 2%).

Overall, youth attending the small but necessary high schools which include alternative schools and community day schools, are behaviorally more at risk. They are more likely to be sexually active, have more sexual partners, are less likely to have used condoms the last time they had sex, and are more likely to experiment with drugs. Many junior high students are also engaging in very high risk behaviors, and African American middle school youth were more likely to be sexually active.

To develop more effective HIV prevention programs, it is important to know the determinants of HIV-preventive sexual behavior (especially consistent condom use). A recent review by DiClemente suggested that four variables are predictive of condom use: 1) perceived peer norms; 2) communication with sex partners; 3) perceived efficacy of condoms to prevent HIV infection; and 4) adolescents' perceived costs associated with using condoms.

Unfortunately few local behavioral studies have been conducted with young adults (17-24 years) in the San Francisco college systems. San Francisco Community College System recently conducted an AIDS needs assessment, yet it is not possible to generalize this study's results, since it did not stratify by age when looking at sexual behaviors (about a third of the students were over 30 years old). However, studies outside of San Francisco have shown that college students are behaviorally at significant risk for HIV infection and STDs are being reported at epidemic rates by campus student health services.

Recommendations for Prevention

Early onset of sexual activity, multiple partners among those who are sexually active and the percentage of youths engaging in unprotected sex could place in-school youth at risk for HIV infection. In-school youth need more skills based training in communication and negotiation as well as social skills to resist negative peer influences. Cultural differences in sexual communication skills should not be overlooked when developing such interventions. More initial intervention time may need to be devoted to overcoming cultural barriers against discussion of HIV and sexual behaviors when working with Chinese, Filipino and Latino students. Peer-assisted behavioral interventions might lead more readily to the adoption of HIV-preventive social skills.

Students attending alternative schools may be at greater risk for HIV infection and prevention programs should address these differences. Specific prevention programs (including condom distribution) should *also* be designed for middle school and grade school youth since the mean age of sexual debut in most studies was around 12 years. Finally, because 16% of students in San Francisco have lived in the United States for three years or less, it is important for prevention programs to be culturally specific and in the language of choice for recent immigrants.

High risk sexual and drug use behaviors are not isolated from other life issues for youth. Ultimately, HIV prevention for youth should become more holistic and integrated into all facets of adolescents lives. Prevention for in school youth should include prevention programs for young adults who are attending college.

Recommendations for Future Research

Although the large scale surveys (YRBS) are important, they have limited data regarding sexual practices, especially for gay, lesbian or bisexual youth. To understand the behavioral risk of students, it is necessary to ask more detailed sexual behavior and drug use questions. Questions about homosexuality should be included on all surveys. When such questions are not asked, youth who have had sex with someone of the same sex may feel there is something wrong with them and may be reluctant to talk about such behaviors in the future. This can only hamper HIV prevention efforts.

There is little information available that describes how adolescents avoid risk-taking behaviors, even in high risk social environments. Further research to understand the variables that influence adolescents' use of HIV-preventive behaviors. The identification of such variables is critical to developing effective programs that promote the adoption and maintenance of HIV-preventive behavior.

Future research should explore the social context of sexual and drug use behaviors as well as serial monogamy and partner choice in order to develop youth specific interventions. Exploring behavioral differences among different youth culture groups "who youth hang with" may help in the development and evaluation of more specific interventions.

There needs to be more research that identifies the impact of gender-role differences and cultural differences in sexual behavior. Future research should also address forced sex and sexual abuse (one study found that 18% of high school students reported forced sex) as well as other psychosocial issues that youth experience.

Youth should be involved in the development of focus groups, surveys and interviews in an effort to assist researchers in asking questions that are more youth specific. The development of variables should include a process for standardizing important behavioral variables and related constructs. To date, lack of standardized measures for assessing some of these variables and constructs make cross-study comparisons difficult.

Future studies should look at the risk behaviors of young adults in San Francisco college systems. At a minimum, the KABBs and needs assessments conducted for community, city, and state colleges need to be improved.

Comparison of AIDS Knowledge & HIV-Related Behaviors Among Adolescents in Low & High AIDS Prevalence Communities
DiClemente RJ, Brown LK
Journal of Adolescent Health; 1993; 14:231-236

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Limitations
• Self-administered survey • 1989 • 796 high school students enrolled in Life Education Classes in 9 High Schools in San Francisco	• 54% female • 12% Af-Am • 56% Asian/PI • 11% Latino • 15% White • 7% Other	• 32% sexually active • 17% had sexual debut at 12 yrs or younger • 44% had more than 2 partners in past yr • 30% rarely or never use condoms	• 25% of those who drink report having unprotected sex while "high" on alcohol		• School based programs that stress skills training are needed • Pediatricians and other health care providers should become involved in helping adolescents adopt and maintain HIV preventive behaviors	• Cross-sectional design • No test-retest reliability • CDC designed tool (1989 version), may be outdated

HIV Knowledge Communication and Risk Behaviors Among White, Chinese-Filipino-American Adolescents in a High Prevalence AIDS Epicenter: A Comparative Analysis
Horan PF, DiClemente RJ.
Ethnicity & Disease, 1993: 3:97-105

Study Design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross-sectional self administered survey, • 1989 • 1,272 high school students (10th and 11th grade) filled out survey in either family life or social studies classes • Only students who identified as Chinese, Filipino or White were in sample	• Females: (52% of Chinese; 59% of Filipino; and 58% of White) • Chinese were 46.9% of original sample • Filipinos were 16.3% of the original sample • Whites were 8.6%	• Only 13% of Chinese students were sexually active • 32% of Filipinos were sexually active • 37% of Whites were sexually active • Among sexually active students, no racial ethnic differences were found for the total sexual behavior risk index • Chinese students were less able to communicate with others about HIV disease and prevention • Chinese and Filipino students had less misconceptions, but Whites had higher knowledge prevention	• 2.1 % reported using injection drugs (2.2% of White students, 3.3% of Filipino students, and 1.4 of White students		• Chinese and Filipino students should not be grouped together since there were significant differences in sexual activity and communication skills • Filipino students have sexual activity rates similar to those of White students but share poorer HIV prevention knowledge and lesser ability talk about HIV • Diversity reinforces the health promotion message to ethnic populations that risk of infection is associated with the behavior of the individual and not with group membership • More initial intervention time may need to be devoted to overcoming cultural barriers against discussion of HIV and sexual behaviors when working with Chinese and Filipino students	• Cultural differences and difficulty in communicating about sex, may have contributed to lower rates of sexual activity among Chinese students • Sexual behaviors questions were not very specific

Determinants of Condom Use Among Junior High School Students in a Minority, Inner-City School District
DiClemente RJ, Durbin M, Siegel D, Drasnovsky F, Lazarus N, Comacho T
Pediatrics, February 1993: 89(2): 197-202

Study design, sample size and method, entry criteria, year of sample	Sample demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• cross sectional, self-administered, anonymous KABB survey • 1988 • 403 sexually active junior high school students in San Francisco (selected from a larger sample described above) • response rate = 95%	• the sexually active subsample described in this article were disproportionately African-American and male • 64% male • 58% Afr-Amer • 10% Asian / PI • 21% Latino • 6% White • 6% Other	• 21% reported never using condoms • 15% reported rarely using condoms		Factors that predict consistent condom use: • Belief that condoms prevent HIV transmission • Low perceived cost associated w/ condom use • Lower number of lifetime sexual partners Factors <u>not</u> associated w/ consistent use: • Age • Age of sexual debut • Race/ethnicity • HIV knowledge, • Perceived efficacy to avoid infection • Alcohol/drug use	• School and community based HIV prevention programs need to go beyond didactic transfer of information and address the factors associated w/ condom use • Health care professionals can play an important role in counseling adolescents about effective HIV prevention and dispelling misperceptions which may hinder consistent condom use	• Cross sectional survey • Self reported sexual behaviors may be low • No measures of SES

Factors Associated With Multiple Sexual Partners Among Junior High School Students
Durbin M, DiClemente RJ, Siegal D, Krasnovsky F, Lazarus N, Camacho T
Journal of Adolescent Health, 1993: 14:202-207

Study design, sample size and method, entry criteria, year of sample	Population Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross-sectional, self administered, anonymous KABB survey, •1988 • Administered to middle school students • Response Rate = 95%	• 36% female • 58% African-Am • 11% Asian/PI • 21% Latino • 6% White • 6% Other	• 21% sexually active • 62% reported first sexual debut at 12 yrs or less • 40% rarely or never used condoms during sex • 22% reported 3-5 lifetimes sexual partners • 21% reported 6 or more partners		Predictors of Lifetime Partners: • Sexual debut before 13 years • Being male • Being African-Amer. Factors <u>not</u> associated: • Being Asian or PI • HIV knowledge • Self efficacy • Condom use • Alcohol & drug use	• Early onset of sexual activity and percentage reporting multiple partners may place these middle school adolescents at risk for HIV infection • Programs will have to identify and then target each specific HIV risk behavior and its motivation for different populations • Research & prevention should address serial monogamy & partner choice	• No measure of SES used when looking at racial/ethnic differences • Small sample size

Health Risk Behaviors and Health Concerns Among Young Adolescents
Millstein SG, Irwin CE, Adler NE, Cohn L, Kegeles SM, Dolcini MM
Pediatrics, March 1992; 3:422-428

Study design, sample size and method, entry criteria, year of sample	Population Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross sectional survey • 1986 • 563 adolescents aged 11-14 were recruited from middle school classrooms • Response Rate = 90%	• 52% female • 18% Af-Am • 17% Asian / PI • 14% Latino • 29% White • 22% mixed other • Mean age = 13 yrs	• 21% sexually active 35% boys vs.. 8% girls • 50% of Af-American youth; 23% of Latinos, 11% of Whites & 8% of Asians were sexually active. • 43% had sexual debut prior to 11 yrs • 51% reported having sex w/ out birth control • 37% had sex w/ out taking precautions for STDs	• 73% used alcohol • 31% marijuana • 5% some form of cocaine	• Adolescents who were sexually active were more likely to use alcohol and other illicit substances	• Early onset of alcohol/ drug use and sexual activity could place middle-school youth at risk for HIV infection • Prevention programs should be specifically designed for middle school youth	• Small sample size • Narrow age range • No questions about having sex w/ same sex partners

Psychosocial & Behavioral Factors Associated with Risk of STDs, Including HIV Among Urban High School Students
Shafer MA, Boyer CB
Journal of Pediatrics, November 1991; 826-833

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross sectional, anonymous, self-administered survey • 544 students from 4 high schools in SF • All were 9th graders who filled out survey in PE classes • Response Rate = 54%	• 59% female • 6% Afr-Amer • 43% Asian/PI • 13% Latino • 18% White • 20% mixed/other • Mean age = 15 yrs	• 21% sexually active • mean age of sexual debut (13 years) • 68% infrequent condom use • 18% reported forced sex • 3% reported sex w/ gay or bi man • 6% reported history of STD infection • 6% reported history of pregnancy (self or partner)	• 68% use alcohol (17% use it frequently) • 6% have used crack or other cocaine • 22% use marijuana	• Alcohol & drug use was best predictor of sexual risk behavior • Lower knowledge & perception that peers are not engaging in preventive behaviors were the best predictors of non-use of condoms	• The connection between peer influence & alcohol/drug use and sexual risk behaviors needs to be addressed by prevention programs • It is necessary to evaluate interventions to modify factors associated with risky behavior • Youth need social skills to resist negative peer influences	• Small sample size • Low response rate • Cross-sectional design

High School Youth Behavior Risk Survey.
SFUSD 1993

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Anonymous survey • 1993 • 2,753 high school in San Francisco filled out the Youth Behavior Risk survey in school	• 52% female • 15% Af-Amer • 41% Asian/PI • 17% Latino • 13% White • 12% Other	(Percentages reported for those who are sexually active) • 40% sexually active • 20% had sex debut before 12 yrs • 39% had sex in past 3 months • Of those who had sex in past 3 months, 31% had 2 or more partners • 20% used alcohol &/or other drugs the last time they had sex • 40% did not use a condom the last time they had sex	• 16% had 5 or more drinks in a row on at least one day in the last 30 days •19% used marijuana at least once the last 30 days • 3% used some form of cocaine in the last 30 days • 2% injected drugs at least once		• Early sexual debut, multiple partners among those who are sexually active & the percentage of youths engaging in unprotected sex could place these youth at risk for HIV infection • Youth appropriate interventions should target in school youth • Future research with in school youth should explore the social context of sexual and alcohol drug use behaviors in San Francisco • The relationship between alcohol/drug use and sex should be explored in an effort to design appropriate interventions	• There are no questions about sexual orientation or sexual behaviors with same sex partner • Sexual behavior and drug use questions were very general

High School Youth Behavior Risk Survey.
Comparison of sexually active students in 1993
(Comprehensive high schools versus the small necessary high schools (which include alternative schools & community day schools)
SFUSD 1993

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Anonymous survey • 1993 • 2,753 high school in San Francisco filled out the Youth Behavior Risk survey in school • 709 students were in the small necessary high school sample and 2,044 were in comprehensive sample	• 52% female • 15% Af-Amer • 41% Asian/PI • 17% Latino • 13% White • 12% Other • Demographic differences between comprehensive & small necessary sample not given	• Comparison of risk behaviors (comprehensive HS sample vs.. small, necessary HS sample) • Sexually active: (34% vs.. 62%) • 2 or more sexual partners in past 3 months (60% vs.. 80%) • 6 or more sexual partners in past 3 months: (18% vs.. 34%) • Did not use condom last time had sex: (34% vs.. 48%)	• Comparison of students who have tried various substances: • Alcohol (56% vs.. 74%) • Marijuana (26% vs.. 52%) • Cocaine (4% vs.. 8%) • Other illicit drugs (8% vs.. 18%)		• High school students in the small, necessary schools (which included alternative schools & community day schools), are more likely to be sexually active, have more sexual partners, are less likely to have used condoms the last time they had sex and are more likely to have tried alcohol and other drugs (including illegal drugs) • Students attending alternative schools may be at greater risk for HIV infection. Prevention programs should explore these differences in students (there may be similar differences among individual high schools)	• Small necessary sample included a mix of community day schools and alternative schools. Some of the alternative schools were academic specialty schools and it is not clear if students here were as high risk as those in community day schools.

HOMELESS AND RUNAWAY YOUTH

Published Behavioral Studies:

1. The Neglected Health Care Needs of Street Youth.
   Sherman DJ
   Public Health Reports, July/August 1992; 107(4): 433-440

2. Baseline Data from AIDS Education Street Outreach Project (AESOP) San Francisco Site, 1992
   (Baseline data has not been published or distributed; wave 4 is currently being collected)

3. Providing AIDS Related Services to Arrived Immigrant and Refugee Youth.
   Kennedy M
   Youth AIDS Education and Prevention, Supplement Fall 1992; 82-86

4. Homeless and Runaway Youth Mental Health Issues: No Access to the System
   Kennedy MR
   Journal of Adolescent Health 1991; 12: 576-579

5. Homeless Youth and HIV Infection
   Rotheram-Borus MJ, Koopman C, Ehrhardt AA
   American Psychologist 1991; 46(11): 1188-1197

HOMELESS AND RUNAWAY YOUTH

Behavioral Summary

The San Francisco Homeless and Runaway Youth Network estimates that there are 2,000 homeless and runaway youth in San Francisco. All of the experiences and factors that put in-school youth at risk for HIV infection, are more profound for youth who live on the streets, in shelters, hotels, or in squats. Added dimensions of physical and sexual abuse, financial difficulty, and social, physical and psychological isolation make street youth an important population for HIV prevention.

Nationally, about 6% of homeless adolescents identify themselves as gay or lesbian (National Network of Runaway and Youth Services, 1991). High seroprevalence rates for youth attending San Francisco youth centers (26% among young men who have sex with men; 50% among men who have sex with men and inject drugs; and 2.8% among women who inject drugs) indicate these homeless youth are in need of increased prevention services.

Although a similar number of homeless and non-homeless youth are sexually active and condom use is about the same, homeless youth are at increased risk due to other variables. In San Francisco, homeless youth have been found to have higher rates of STDs, drug use, multiple partners, and most studies found that about 30% have been sexually abused. Furthermore, an undocumented, but significant percentage of youth on the streets are recent immigrants, and some street youth engage in prostitution in order to obtain money, food, or drugs.

Initial results from the AIDS Evaluation of Street Outreach Project (AESOP) indicate that homeless youth in the Haight are engaging in significantly more injection drug use than school samples. Baseline behavioral data showed that 31% had injected drugs and 15% did so in the past month. Of those who injected in the past month, 25% (6/24) used a needle with other people the last time they shot up. A NIDA study in Tenderloin area and further AESOP analyses will give more useful information on the sexual and drug use risks of subpopulations of homeless youth in San Francisco in the future.

Recommendations for Prevention

High levels of unprotected sex, drug use, trading sex for money or drugs, and a history of sexual abuse may put homeless and runaway youth at risk for HIV infection. Prevention efforts should be targeted to specific groups of

runaway youth who may be particularly high risk (i.e., young gay and bisexual men, young IDUs, recent immigrants, crack users and those who engage in prostitution). HIV prevention for homeless and runaway youth can not take place in isolation of other social problems that street youth face. Involvement of more youth in the development, implementation and evaluation of prevention efforts will lead to more appropriate programs for this population.

HIV prevention programs should be funded in temporary shelters, food service agencies and other agencies that homeless youth may use (health clinics, drug treatment programs, STD/family planning clinics, shelters, and community youth programs). Staff at the aforementioned agencies should be trained for appropriate counseling and referral. Although these agencies and programs may be important venues for reaching homeless and runaway youth, outreach to youth who are not accessing the system should be made. Needle exchange and condom distribution should be made readily available to homeless youth.

Recommendation for Future Research

Larger behavioral surveys such as the YRBS should be conducted with out of school youth. Such behavioral research should document sociodemographics, risk behaviors, preventive behaviors, and other sociocultural factors of runaway youth in order to develop appropriate interventions and evaluate their effectiveness.

Future research should explore types of interventions that might be effective with this population. This will require involving homeless youth in the process of developing and evaluating interventions.

The Neglected Health Care Needs of Street Youth
Sherman DJ
Public Health Reports, July/August 1992; 107(4): 433-440.

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross Sectional survey administered to 214 youth aged 10-18 from 3 youth clinics • YGC, Larkin Street, Huckleberry House • June-November 1990 • Response Rate = Only used data from 214 youth who completed a medical exam (9% of the total number seen at the clinics)	• All youth stated that they lived on the streets • 22% were born outside the US • 60% female • 24% Afr-Am • 7% Asian/PI • 22% Latino • 43% White • 2% Native Amer • 2% Other • Mean age = 16.7 yrs	• 90% sexually active • Mean age of sexual debut was 13.5 years • 84% said they were straight, 9% gay and 2% bisexual • 85% had vaginal sex • 61% did not use a condom the last time they had vaginal sex • 14% had anal sex • 30% said they were sexually abused as children (sexual abuse was related to trading sex for $ or drugs) • 40% had a history of STD infection and STD screening confirmed 21% new cases	• Use in past 2 mos.: Alcohol (40%) Marijuana (31%) LSD (10%) Cocaine (9%) • 15% injected drugs • 12% had IDU partners		• High levels of unprotected sex, drug use and a history of sexual abuse has implications for prevention with homeless runaway adolescents	• Exclusive use of data collected from those receiving complete medical history workups and physical exams may introduce selection bias • Small, self-referred sample • Interview instrument was designed for clinical rather than research use

Baseline Estimates from AIDS Education Street Outreach Project (AESOP)
San Francisco Site, 1992
(Baseline data has not been published or distributed; wave 4 is currently being collected).

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross Sectional multi-site survey designed to evaluate street outreach • Street recruitment • Anonymous interview • Entry criteria were current homelessness or involvement in street economy • Recruitment age was 24 yrs or younger • 162 youth were recruited and interviewed from the Haight site wave 1 (baseline)	• 30% female • 14% were 17 yrs or younger • 14% were 15-17 • 58 % were 18-20 • 27% were 21-23 • 78% were currently living on the streets (65% had been on the streets for a year or more, 9% for 6 months to a year, 15% from 2 to 6 months, 11% for 30 days or less) • 6% Afr-American • 1% Asian/PI • 4% Latino • 7% Native American • 80% White • 2% Other • 83% heterosexual • 14% bisexual • none identified as gay or lesbian	• 35% have a current main sexual partner • 32% had sex with someone other than a main partner in the past 30 days • Condom use w/main 93% had vaginal sex in the past 30 days, and 40% used a condom the last time they had vaginal sex • Condom use w/ other 98% had vaginal sex with a non-steady partner in past 30 days, and 59% used a condom the last time they had vaginal sex • Very few people reported anal sex with any type of partner, and most used condoms • About 65% had oral sex w/ both main and other partners, but only a few used condoms for oral sex • ___% had a STD	• 31% reported ever injecting drugs • 15% (n = 24) injected in the past 30 days • Among those who injected in the past 30 days: 42% injected cocaine, 83% injected heroin, 38% injected speed and 17% speedballs • 58% of IDUs had been in treatment • Of those who injected in the past 30 days, 25% (6/24) used a needle with other people the last time they shot up, 17% (4/24) used only with their partner • Most recent injectors said it was easy to get new needles when they needed them • 44% used crack • 77% used cocaine • 46% used heroin • 59% used speed		• Although there were few youth who self reported anal sex, most were sexually active and condom use was fairly low with vaginal sex • Condom use was lower w/ main partners than with non-steady partners. Future research should look into the risk of subject's main partners • Drug use was high and in particular, recent injection drug use may be putting these youth at risk for HIV infection • Although most respondents said it was easy to get new needles when they needed them, 42% reported sharing with a partner or other people the last time they shot up • The social context of drug use for these youth should be looked at. If new needles are available and not being used, other factors need to be included in prevention	• Small sample size • Non-random sample limits generalizability beyond Haight area • Sample was predominantly White and heterosexual

Providing AIDS Related Services to Recently Arrived Immigrant and Refugee Youth
Kennedy M
AIDS Education and Prevention, Supplement Fall 1992; 82-86.

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Notes from the field • During the period from 1988 to 1990, the percentage of Latino youth served at the Larkin Street Youth Center increased from 15 to 20% of the total population served. • In the past 8 months, YGC provided services to 93 self identified Latino youth	• Over 90% of the 93 Latino youth seen were from Mexico or Central America • 85% were male • Mean age = 16 years • All males were from Mexico or Central America • 6 identified as gay and 2 as bisexual	• 15% reported childhood sexual abuse • Other sexual behaviors were not measured, but the author noted that many youth may be at risk for HIV if they are taken advantage of or are forced to sell sex for money in order to survive • The author also notes that most who are interviewed upon intake by a Spanish interviewer have low AIDS knowledge	•		• San Francisco is a city to which large numbers of troubled children from across the country and from Mexico and Central America come. Culturally relevant programs need to respond to the needs of these youth (their mistrust, fear of being reported to immigration, trauma from immigrating, and possibly, high risk activities to survive)	• This is not a planned study, but is included to shed light on the amount of recent immigrants seen at Larkin Street and their special needs

Homeless and Runaway Youth Mental Health Issues: No access to the system
Kennedy MR
Journal of Adolescent Health 1991; 12:576-579

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• From June 1, 1988 to July 1, 1989, Larkin Street Youth Center saw over 1,000 homeless and runaway youths • Intake data from 100 youth who received long-term case management services at Larkin Street Youth Center is evaluated	• 78% came from outside SF area, 38% from outside the state • 63% females • 13% African-Amer • 3% Asian • 13% Latino • 68% White • Mean age =- 16 yrs	• 79% self-identified as heterosexual • 21% self-identified as gay, lesbian, bisexual, or undecided • 60% reported they had never received $ or drugs for sex • 62% reported multiple abuse in the home before leaving • 30% were sexually abused	The following drugs were used by youth: • 72% marijuana • 40% speed • 37% crack • 42% cocaine • 42% hallucinogens • 16% PCP • 15% Heroin		• Larkin Street sees many homeless and runaway youth that may be at high risk for HIV infection • Future research should explore types of interventions that might be effective with this population, this may require learning more about the sexual behaviors, culture, and lifestyle of these youth	• This is not a planned study, but is included to shed light on some of the behaviors and needs of homeless and runaway youth seen at Larkin Street • Not a representative sample (even of Larkin Street clients) • Small sample size

INCARCERATED YOUTH AND CLINIC BASED STUDIES OF YOUTH

Published Behavioral Studies:

1. Relationships Between Drug Use and Sexual Behaviors and the Occurrence of Sexually Transmitted Diseases Among High Risk Male Youth.
   Shafer MA, Hilton JF, Ekstrand M, Keogh J, Gee L, DiGiorgia-Haag L, Shalwitz J, Schachter J
   Sexually Transmitted Diseases, Nov-Dec 1993; 307-313

2. Risks of Human Immunodeficiency Virus Among Adolescents Attending Three Diverse Clinics.
   Moscicki AB, Millstein SG, Broering J, Irwin CE
   Adolescent Medicine, May 1993; 813-820

3. HIV-Related Risk Behaviors Among Psychiatrically Hospitalized Adolescents and School Based Adolescents.
   Clemente RJ, Ponton LE
   American Journal of Psychiatry, February 1993; 150 (2): 324 - 325.

4. Comparison of AIDS Knowledge, Attitudes, Behaviors Among Incarcerated Adolescents and a Public School Sample in San Francisco.
   DiClemente RJ, Lanier MM, Horan PF, Lodico M
   American Journal of Public Health, 1991; 81: 626-630

5. Predictors of HIV-Preventive Sexual Behavior in a High Risk Adolescent Population: The Influence of Peer Norms and Sexual Communication on Adolescents Consistent Use of Condoms.
   DiClemente RJ
   Journal of Adolescent Health, 1991; 12:385-390

KABB Behavioral Summaries:

6. 1992 City Clinic KABB Survey
   Results for Teens
   DPH, San Francisco City Clinic; 1993

INCARCERATED YOUTH AND CLINIC BASED STUDIES OF YOUTH

Behavioral Summary

Juvenile detention centers, drug treatment programs, STD clinics, and other teen clinics are a point of entry for many youth who may be in need of HIV prevention. Such sites serve a cross-section of youth who are behaviorally at greater risk for HIV infection than school based youth populations.

In one study that compared incarcerated youth with a comparable sample of school youth, incarcerated adolescents were more likely to be sexually active (76% vs. 48%), have two or more partners in the past year (73% vs. 8%), have their sexual debut at 12 years or younger (52% vs. 26%), and have a history of injection drug use (13% vs. 4%). Only 29% of this incarcerated sample always use condoms. Another study of adolescents attending three teen health clinics found that 20% of females and 27% of males engaged in anal sex and most of these youth rarely or never used condoms.

All of the incarcerated or clinic based studies of youth found high levels of alcohol and drug use and the practice of having sex while high was greater in these samples than school based samples. In one study of incarcerated young men, frequent alcohol use was an independent risk factor for STD infection. In addition, 14% of this population reported trading sex for drugs. In addition to the aforementioned behavioral risks, populations of youth accessing treatment for substance abuse, STDs, and other behavioral and health problems are often dealing with complex issues that may exacerbate HIV risk behaviors.

Recommendations for Prevention

There is a need for HIV primary prevention programs within incarceration facilities, substance abuse treatment agencies, STD and teen clinics. Because these agencies are a point of entry and way of reaching youth who may be at high risk for HIV infection, training staff in HIV prevention is critical. Prevention programs should be integrated into the services offered by these agencies and youth should be involved in program development and implementation.

Prevention programs should emphasize skills training and norm setting activities such as developing and refining communication skills around sexual negotiation and modifying perceptions around peer norms. Prevention programs will have to overcome particular barriers to behavior

change such as low motivation for self-protection and lack of self-esteem and will have to find creative ways to address issues related to combining alcohol and drug use with sexual activity.

Although there are very few adolescents receiving psychiatric treatment in inpatient facilities, initial research indicates that psychiatrically hospitalized adolescents report a high rate of sexual and drug risk behaviors associated with HIV transmission. To be effective, HIV prevention programs will have to be tailored to meet the particular needs of psychiatrically hospitalized youth.

Recommendations for Future Research

Site specific intervention and evaluation research for HIV prevention with incarcerated youth and youth attending different clinics is urgently needed. Such research should explore differences between subgroups of youth. Future studies should also look more closely at psychosocial, developmental and situational factors that may influence health damaging and health promoting behaviors.

Relationship Between Drug Use and Sexual Behaviors and the Occurrence of Sexually Transmitted Diseases Among High Risk Male Youth
Shafer MA, Hilton JF, Ekstrand M, Keogh J, Gee L, DiGiorgia-Haag L, Shalwitz J, Schachter J
Sexually Transmitted Diseases, Nov-Dec 1993; 307-313

Study design, sample size and method, entry criteria, year of sample	Population Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross sectional survey • 458 asymptomatic males attending a youth detention center • Eligibility: English speaking and sexually active in past 3 months • Ineligibility: symptoms of STD, had taken antibiotics, mental health problems • Asians (n=15) and other (n=29) were excluded from analyses • Refusal rate = 25% • did not differ on main demographics	• Mean age = 16 • 65% Afr-Amer • 16% Multi-Ethnic • 11% Latino • 7% White • 27% had 7 or more prior detentions • 15% had a diagnosis of at least 1 STD at entry • 29% had a past history of STD • African Americans had highest rate of STD	• 68% had two or more partners in past 3 mos. • 22% always used condoms • Condom use was lower with main partners than other partners (30% vs. 55%) • Medium number of lifetime partners was 15 • 14% reported having exchanged sex for drugs	Alcohol & drug use in the past 3 months: • 77% alcohol • 74% marijuana • 24% other illicit • 76% had sex while high	Predictors of STD using Multivariate Analysis: <u>African-Americans / multi-Ethnic</u>: • Multiple partners in past 3 months • Inconsistent condom use • Frequent alcohol use <u>White/Hispanic</u>: • Only frequent alcohol use approached significance (although low numbers may have limited the model)	• More investigation of the role of alcohol and STD risk is warranted • Prevention interventions must consider the role of race/ethnicity • The role of sexual partners in increasing the risk for STDs & HIV (especially by race/ethnicity) should be further investigated for young men • It may be necessary to employ different strategies to effectively decrease risk depending on whether the partner is considered a main partner or "other" partner • Research must define both the barriers and supports for successful condom use including steps toward intervention programs • Interventions should be directed at the reduction of alcohol use and/or the combination of drug use with sex	• No control group • Small, non-random sample • Low levels of same sex sexual relationships (perhaps due to feeling that admitting to same sex experiences may have negative consequences for them while incarcerated.

Risks of Human Immunodeficiency Virus Among Adolescents Attending Three Diverse Clinics
Moscicki AB, Millstein SG, Broering J, Irwin CE
Adolescent Medicine, May 1993: 813-820

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross sectional, interview survey of youth attending a Planned Parenthood clinic (SF), a UCSF clinic, or a public health clinic in Oakland • Sept 1987 to June 1989 • 20% of males refused to participate. • No response rate for females was given.	671 females and 207 male adolescents • Public Clinic: 94% Af-Am • Other Clinics: 16% Af-Am 8% Asian / PI 19% Latino 49% White 10% Other • Mean age = 17 yrs	• 40% of females & 70% of males had 4 or more lifetime partners •56% of females & 67% of males never use condoms w/ new partners • 20% of females and 27% of males reported engaging in heterosexual anal sex • Of those who reported anal sex, 88% of females and 79% of males rarely or never used condoms • 7% of females & 7% of males reported some type of homosexual experience	• 57% of females and 53% of males reported moderate to heavy alcohol use • 30% of males and females reported moderate to heavy marijuana use • 3% of males and females reported injection drug use • 29% of females and 13% of males reported combining alcohol use with sex • Among alcohol users, most said it was easier to have sex, they enjoyed sex more and worried about pregnancy less when high • 13% of females, 17% of males combine drugs w/ sex		• Behaviors that put youth at risk were found at all clinic sites. • Health Professionals need to ask all clients about risk behaviors, regardless of chief complaint or demographic makeup • Prevention programs should address the issues around combining alcohol and drug use with sex.	• Only females who were sexually active or obtaining a pelvic exam were sampled. • At Planned Parenthood, males who were waiting with their girlfriends were sampled because so few men receive services there. • Patients were excluded if they did not speak English

HIV-Related Risk Behaviors Among Psychiatrically Hospitalized Adolescents and School Based Adolescents
DiClemente RJ, Ponton LE
American Journal of Psychiatry, February 1993: 150(2):324-325

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors of Behaviors	Implications for Prevention	Limitations
• Cross sectional interview administer to 76 adolescents at an in patient psychiatric service • January 1988 to April 1989 • Response Rate = 100%. The patients interviewed represent all admissions	.	• 53% were sexually active • 50% had their sexual debut at age 12 or younger • 78% rarely or never used condoms • 63% had more than 3 lifetime partners • 20% (8) reported past homosexual experience • 20% (8) reported having sex with IDU	• 9% (7) reported IDU (all of them shared needles) • Of the 20 subjects who reported using other illicit drugs, 3 said they traded sex for drugs		• High rates of sexual activity and unprotected sex warrants HIV prevention programs that are tailored to the needs of psychiatrically hospitalized adolescents	• Very small sample size (not many adolescents receiving treatment in inpatient facilities) • Comparison with school based sample inappropriate because survey instrument was so different.

Comparison of AIDS Knowledge, Attitudes, Behaviors Among Incarcerated Adolescents and a Public School Sample in San Francisco
DiClemente RJ, Lanier MM, Horan PF, Lodico M.
American Journal of Public Health, 1991; 81:628-630

Study design, sample size and method, entry criteria, year of sample	Population Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross sectional survey of 113 incarcerated youth from Youth Guidance center and 802 students from 9 high schools •1988 • Response Rate = 97% for Incarcerated Youth & 91% for School Youth	• Incarcerated youth more likely to be male (76% vs. 48%), 17 years or older (30% vs.. 15%) and African American (65% vs.. 12%). • Incarcerated youth were less likely to be Asian (6% vs. 56%) • Latinos were 10% of the incarcerated & 14% of the school populations • Whites were 11% of both incarcerated & school youth ** Multivariate Logistic Regression was used to adjust for demographic differences between samples	Comparison of behaviors. Incarcerated youth vs. school youth: • sexually active (99% vs. 28%) • 2 or more partners in the past year (73% vs. 8%) • three or more lifetime partners (84% vs. 15%) • sexual debut at 12 yrs of age or younger (52% vs. 26%) • always use condoms (29% vs.. 37%)	• History of IDU incarcerated = 13% school youth = 4%		• Incarcerated youth were more likely to be sexually active, initiated sex at an earlier age, had more sexual partners. A combination of these behaviors may put these youth at increased risk for HIV infection • AIDS prevention programs should be specifically targeted for incarcerated youth • Such programs will have to overcome particular barriers to behavior change, such as low motivation for self-protection & lack of self-esteem. • Interventions should emphasize ways of reducing infection rather than changing behaviors	• Sample size of incarcerated youth was small. • Cross sectional survey • Questions did not address gay or lesbian issues or sexuality

Predictors of HIV-Preventive Sexual Behavior in a High Risk Adolescent Population: The Influence of Peer Norms and Sexual Communication on Adolescents Consistent Use of Condoms.
DiClemente RJ
Journal of Adolescent Health, 1991; Society for Adolescent Health 12:385-390

Study design, sample size and method, entry criteria, year of sample	Population Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross sectional survey of 112 adolescents at SF juvenile detention facility (YGC) • February 1988 *Same sample of incarcerated youth described above. This article emphasizes predictors of condom use among incarcerated sample	• Male (76%) • Afr-Amer (65%) • Asian / PI (6%) • Latino (10%) • White (11%) • Other (8%)	• 99% were sexually active • 73% reported 2 or more partners in the past yr • 84% reported three or more lifetime partners • 52% had their sexual debut at 12 yrs of age or younger • 29% always use condoms		Predictors of consistent condom use: • Not being African - American • Perceived peer norms as supportive of condom use • Communication with sex partners about AIDS Factors <u>not</u> associated with consistent condom use: • age, gender, general HIV knowledge, knowledge of HIV risk reduction strategies, age at sexual debut, # of lifetime partners, & # partners in past year	• Prevention programs for incarcerated youth should emphasize skills training and norm setting activities such as developing and refining communication skills around sexual negotiation and modifying perceptions around peer norms	• Small sample size (especially of non-African-American youth) this may limit the reliability of the findings of ethnic differences • No measure of SES and combining ethnic groups that have distinct cultural variation limits the finding that African-Americans are less likely to use condoms consistently. • Use of cross-sectional design

1992 City Clinic KABB Survey
San Francisco City Clinic (results for teens)

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors of Behaviors	Implications for Prevention	Limitations
• Cross sectional, self-administered, anonymous KABB survey • June and July 1992 • Response Rate = 60%	• 60% female • 48% African Am • 10% Asian/PI • 20% Latino • 20% White • 2% other	• 42% reported 2 or more sexual partners in the past 3 months • 25% reported never using condoms in the past 12 months • 46% reported having sex while very high on alcohol or other drugs • 15% reported being so high on alcohol or other drugs that they forgot what they did while having sex • 12% encouraged someone to use alcohol or drugs to make it easier to have sex with them	• 31% reported daily or weekly alcohol use • 32% reported daily or weekly marijuana use • 12% reported ever using crack		• High rates of unprotected sex, multiple partners in the past 3 months and having sex while high may place these youth at risk for HIV infection. • Prevention programs should be specifically designed to address the combination of alcohol and drug use and sex among youth attending STD clinics	• Small sample size • STD clinic patients may report more high risk behaviors

GAY AND BISEXUAL MEN

Published Behavioral Studies:

1. Are Bisexually Identified Men in San Francisco a Common Vector for Spreading HIV Infection to Women?
Maria L. Ekstrand, PhD, Thomas J. Coates, PhD, Joseph R. Guydish, PhD, MPH, Walter H. Hauk PhD, Linda Collette, MS and Stephen B. Hulley, MD,MPH
American Journal of Public Health, June 1994; 84(6):915-919

2. Racial and Ethnic Differences in Human Immunodeficiency Virus Type 1 (HIV-1) Seroprevalence among Homosexual and Bisexual Men.
Philippa J. Easterbrook, Joan S. Chmiel, Donald R. Hoover, Alfred J. Saah, Richard A. Kaslow, Lawrence A. Kingsley, and Roger Detels, for the Multicenter AIDS Cohort Study
American Journal of Epidemiology, 1993; 138(6):415-429

3. High-Risk Sexual Behavior and Condom Use among Gay and Bisexual African-American Men.
John L. Peterson, PhD, Thomas J. Coates, PhD, Joseph A. Catania, PhD, Lee Middleton, BA, Bobby Hilliard, MA, and Norma Hearst, MD, MPH
American Journal of Public Health, November 1992; 82(11):1490-1494

4. Changes in Condom Use Among Homosexual Men in San Francisco.
Joseph A. Catania, Thomas J. Coates, Ron Stall, Larry Bye, Susan M. Kegeles, Frank Capell, Jeff Henne, Leon McKusick, Steven Morin, Heather Turner, Lance Pollack
Health Psychology, 1991; 10(3):190-199

5. Homosexual Men Who Engage in High-Risk Sexual Behavior: A Multicenter Comparison.
Lydia S. Doll, PhD, Robert H. Byers, PhD, Gail Bolan, MD, John M. Douglas, Jr., MD, Patricia M. Moss, MSN, Peter D. Weller, PhD, Dan Joy, MSW, Brad N. Bartholow, MA, and Janet S. Harrison, MA
Sexually Transmitted Diseases, July - September 1991; 18(3):170-175

6. Relapse from safer sex: the next challenge for AIDS prevention efforts.
Stall R; Ekstrand M; Pollack L; McKusick L; Coates TJ.
Journal of Acquired Immune Deficiency Syndromes, 1990; 3(12): 1181-7.

7. High-Risk Sexual Behavior and Knowledge of HIV Antibody Status in the San Francisco City Clinic Cohort.
Lynda S. Doll, Paul M. O'Malley, Alan L. Pershing, William W. Darrow, Nancy A. Hessol, Alan R. Lifson.
Health Psychology, 1990, 9(3):253-265

8. Longitudinal Predictors of Reductions in Unprotected Anal Intercourse among Gay Men in San Francisco: The AIDS Behavioral Research Project.
Leon McKusick, PhD, Thomas J. Coates, PhD, Stephen F. Morin, PhD, Lance Pollack, MA and Colleen Hoff
American Journal of Public Health August, 1990; 80(8):978-983

KABB Behavioral Summaries:

9. A Survey of AIDS Knowledge, Attitudes and Behaviors in San Francisco's American-Indian, Filipino and Latino Gay and Bisexual Male Communities.
Prepared for the San Francisco Department of Public Health, AIDS Office by Fairbank, Bregman & Maulin, Inc., May 15, 1991.

10. HIV-Related Knowledge, Attitudes, and Behaviors Among San Francisco's Gay and Bisexual Men: Results from the Fifth Population Based Survey.
Communication Technologies, Inc., SFDPH AIDS Office, San Francisco AIDS Foundation, January 31, 1990

GAY AND BISEXUAL MEN

Behavioral Summary

To date, no sampling frame exists for enumerating gay and bisexual men as a total population. In many studies conducted in San Francisco, researchers have used an estimate of 14% as a standard by which to estimate the total gay and lesbian population of the city. Of that, 8% are believed to be gay and bisexual men, theoretically placing that population anywhere from 55,000 to 58,000. As in most estimates of this nature, we believe the number is not representative of the total gay and bisexual population of the city, and in fact, feel it is a serious under representation of the true number. However, in the absence of more accurate and precise methods to track gay and bisexual men as a distinct population, we accept the 8% figure.

Since the beginning of the HIV/AIDS epidemic in 1981, self-identified gay men have made remarkable changes to their risk behaviors. They were the first focus of attention when the epidemic began, and their communities became the first focus of prevention education programs. Studies of the responses of self-identified gay men to the AIDS epidemic have documented some of the most profound reductions in health risk ever recorded. They have been so successful at adopting new behaviors that it is tempting to view them as a model population with little need for further intervention regarding risk-reduction strategies. However, there is little reason to believe that people will maintain changes made to potentially pleasurable activities such as sexual behavior, even if the changes have substantial health benefits.

In fact, a recent findings suggest that failure to maintain behavior change is the predominant form of unsafe sex among mainstream, gay-identified men. Each unsafe sexual act within populations that have high concentrations of HIV infection suggests far more risk for HIV transmission than a comparable act in populations with low HIV seroprevalence.

Gay and bisexual men of color face formidable challenges to not only practicing safe sex behaviors consistently, but to accessing the information that may give them the skills they need to implement risk-reduction behaviors. In one study of gay and bisexual African American men, it was found that prevention strategies that only target homosexual identification, rather than homosexual behavior, many be ineffective in reaching this population. Overall, prevention strategies that do not reflect the values, culture, and beliefs of the target population will have little effect in initiating behavior change.

Several predictors of risky-sexual behaviors have been identified across studies. They include drug and alcohol use, low self-efficacy to adopt safe sex practices, perceived self-efficacy, being in love, having the same serostatus as one's partner, and condom unavailability. One study also found that Hispanic and black participants were at higher relative risk than white participants. Additionally, several studies found that high-risk taking occurred within specific situations and sexual contexts, not randomly. For example, gay men who report low self-esteem are less likely to assert themselves in situations where there is a likelihood that unsafe sex will occur.

Recommendations for Prevention

Although HIV/AIDS prevention programs targeted to self-identified, mainstream gay men have been largely successful, it is a mistake to believe this population does not require further intervention. Behavior change maintenance may become the critical issue in developing a new generation of HIV/AIDS prevention programs for this population. These programs will require focusing on psychosocial issues, rather than skill-building and negotiating issues as did programs in the past. Understanding the context within which gay men view their sexuality and the meaning it has on various aspects of their lives will be a critical issue to explore in designing newer programs. Also, for self-identified gay men who have experienced repeated loss in their personal lives due to the epidemic, it will be important to examine the impact this has on perceptions of risk and self-worth.

For men who have sex with men but do not self-identify as gay, prevention programs will have to become centered on messages about specific behaviors rather than sexual identities. Appealing to gay men exclusively, regardless of self-identification, has resulted in misperceptions about the virus and how it is transmitted.

For gay men of color, separating prevention information for self-identified gay men and self-identified bisexual men is necessary. One study found that African American gay men were more likely to use condoms if they held strong beliefs that condom use was normative, they had a strong sense of self-efficacy to practice safe sex and they held positive expectations about using condoms. These predictors of condom use must be integrated into programs that target this population in a language and cultural context that is acceptable.

Overall, developing prevention programs for gay men has increasingly become more complex as the epidemic and certain populations age, and as

more and more men of color become disproportionately represented in the tracking of new AIDS cases. Simple, one-shot campaigns, couched in simplistic terms such as "On me, not in me" are no longer effective in reaching the diverse population of gay and bisexual men who live in San Francisco. Sexual identification, culture, age, and values all impact on how messages are both transmitted and received, and these variables must be considered in the design of all prevention programs that target the large population of men who have sex with men.

Recommendations for Future Research

Although many studies have been conducted on cohorts of gay and bisexual men in San Francisco, there is a further need to study this population with an eye on the long term maintenance of behavior change. Identifying the barriers to consistent safe sex practices and testing various strategies to minimize slips to unsafe sex will be critical issues for future prevention programs.

There is also an urgent need to focus behavioral research on gay and bisexual men of color to determine how the effects of culture, race, values and beliefs within specific cultural groups impacts behaviors and perceptions of risk. In light of the evidence that gay and bisexual men of color are seroconverting at alarming rates, this research must begin in earnest and must involve the input of each community being studied in order to ensure the most reliable and accurate data collection techniques.

Are Bisexually Identified Men in San Francisco a Common Vector for Spreading HIV Infection to Women?
Maria L. Ekstrand, PhD, Thomas J. Coates, PhD, Joseph R. Guydish, PhD, MPH, Walter H. Hauk PhD, Linda Collette, MS and Stephen B. Hulley, MD, MPH
American Journal of Public Health, June 1994; 84(6): 915-919

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• Population-based longitudinal cohort of 1034 single men aged 25 through 54 years recruited from the 19 census tracts in San Francisco that had the greatest prevalence of AIDS cases in 1984. • Of total sample, 140 initially identified as bisexual; 85% of these men remained in the study. • Psychosocial questionnaires were administered in 1985, 1987, and 1989.		• 1984 - 1985: Sex w/men only (65%) Sex w/ women only (6%) Sex w/both (26%) Celibate (5%) • Unprotected vaginal sex/multiple female partners (13%) • Unprotected anal sex w/men/multiple male partners (70%) • Unprotected anal sex w/women/multiple female partners (4%) • Unprotected anal w/men and unprotected vaginal w/women (16%) • 1988 - 1989 Sex w/men only (70%) Sex w/ women only (10%) Sex w/both (7%) Celibate (13%) • Unprotected vaginal sex/multiple female partners (3%) • Unprotected anal sex/multiple male partners (12%) • Unprotected anal sex w/women/multiple female partners (1%) • Unprotected anal w/men and unprotected vaginal w/women (2%)		• High-risk subjects reported being less confident of their ability to practice safe sex in a variety of situations than did low-risk subjects. (High risk defined as reporting any unprotected anal sex w/men or women and/or reporting unprotected vaginal sex during the previous 6 months.) • Perceived self-efficacy was the only significant correlate of unprotected sexual intercourse.		• No data on whether study participants were representative of all contacted men in terms of their sexual behaviors or of bisexual men who are married or live in other parts of San Francisco. • Results may not generalize to San Francisco men who have sex w/both men and women but who do not identify themselves as bisexual. • Small sample size. Prevented examination of correlates of risk-taking separately for the gender of the sex partner.

Racial and Ethnic Differences in Human Immunodeficiency Virus Type 1 (HIV-1) Seroprevalence among Homosexual and Bisexual Men.
Philippa J. Easterbrook, Joan S. Chmiel, Donald R. Hoover, Alfred J. Saah, Richard A. Kaslow, Lawrence A. Kingsley, and Roger Detels, for the Multicenter AIDS Cohort Study
American Journal of Epidemiology, 1993; 138(6): 415-429

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• A cross-sectional analysis of baseline HIV-1 seroprevalence and HIV-1 risk factors among 4,475 non-Hispanic white, 234 Hispanic white, and 194 black homosexual men from four centers in the US (Baltimore/Washington, DC, Pittsburgh, Chicago, and LA)	<u>Median age at enrollment</u> Non-Hispanic whites (33) Hispanic whites (30.7) Blacks (32.1) • Compared with whites, fewer Hispanics or blacks were: • High school graduates • In full-time employment • In professional or managerial positions • Self-reported lifetime history of syphilis, rectal gonorrhea, urethral gonorrhea, Hep B more frequent in Hispanics and blacks.	Risk behaviors reported most frequently by Hispanics and least frequently by blacks: • Receptive or insertive anal intercourse • High proportion of anonymous sexual partners • Sexual contact with partners who had or who subsequently developed AIDS	• 26% of Hispanics and 14% of both whites and blacks admitted use of at least four recreational drugs during the 2 years prior to study enrollment. • High-risk practices such as injection drug use and sharing needles were equally infrequent in all racial groups.	<u>Risk factors across all groups</u>: • History of syphilis • Positive hepatitis B serology • Rectal douching <u>Risk factor common to whites and Hispanics only</u>: • Lower educational level <u>Risk factor common to whites and blacks only</u>: • History of rectal gonorrhea <u>Risk factors in all racial/ethnic groups</u>: • Frequent receptive anal intercourse • Receptive fisting • More than 50 lifetime male sexual partners • Sexual contact with a person who developed AIDS • Dildo use • Use over the previous two years of recreational drugs or injectable drugs	• Effective mobilization of prevention and educational strategies in the minority communities should focus on "at risk" behavior among blacks and Hispanics of both sexes, rather than on conventional high-risk groups.	• The relatively high educational level and low use of injectable drugs observed suggests that the three racial groups analyzed may not be representative of the general population.

High-Risk Sexual Behavior and Condom Use among Gay and Bisexual African-American Men
John L. Peterson, PhD, Thomas J. Coates, PhD, Joseph A. Catania, PhD, Lee Middleton, BA, Bobby Hilliard, MA, and Norma Hearst, MD, MPH
American Journal of Public Health, November 1992; 82(11): 1490-1494

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• African-American Men's Health Study Sample size: n = 250 • Face to face, anonymous interviews. • Recruitment over 11 months between 1989 and 1990 in San Francisco, Berkeley, and Oakland. • Inclusion criteria: • race (African American) • sex (male) • age (18 yrs. +) • sexual identification (gay or bisexual)	• Age range (%): < 20 (1) 20-29 (37) 30-39 (60) 39 + (2) • 57% earned $15,000 or less per year. • One-third w/ 12 yrs. education. Half w/ between 13 to 16 yrs. • 89% single • 37% engaged in prostitution • 25% used injection drugs	• In last six months: 22% unprotected anal w/ primary partners. 35% unprotected anal w/ secondary partners. •19% unprotected anal w/ejaculation w/ primary partners. 30% unprotected anal w/ejaculation w/ secondary partners. • Higher prevalence of unprotected anal intercourse in the past 6 months in 1990 than did gay and bisexual White men in 1988.		For unprotected anal intercourse: • Two or more marginal status indicators (e.g., being low income, having been paid for sex, and/or having used injection drugs) • Felt discomfort w/ coming out • Perceived themselves at greater risk • Felt they did not receive support for their concerns about unsafe sex. For condom use: • Strong beliefs that condom use was normative • Strong self-efficacy to practice safer sex • Positive expectations about using condoms.	• Risk reduction campaigns for AA men should increase skills to eroticize condoms and to enhance their use, increase perceptions that condoms can prevent disease, modify norms about condom use. • Separate interventions for AA bisexually identified men. • Financial incentives may have to be offered to recruit eligible participants for interventions as indicated by the difficulty in recruitment for this study.	• Payment of participants may have led to an over representation of men who needed money. • There is no established method to determine the validity of self-reports of sexual behavior.

Changes in Condom Use Among Homosexual Men in San Francisco
Joseph A. Catania, Thomas J. Coates, Ron Stall, Larry Bye, Susan M. Kegeles, Frank Capell, Jeff Henne, Leon McKusick, Steven Morin, Heather Turner, Lance Pollack
Health Psychology, 1991; 10(3), 190-199

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• Study consisted on a longitudinal cohort and three cross-sectional samples of gay men between 1984 and 1987. • Respondents all self-identified gay men residing in San Francisco. Sampled from a Metromail Corporation list of SF households w/ listed telephone numbers. • Secondary sources: voter registration lists, post office change-of-address forms, insurance lists, driver's license and vehicle registration data. • Respondents interviewed by telephone.						

Homosexual Men Who Engage in High-Risk Sexual Behavior: A Multicenter Comparison.
Lydia S. Doll, PhD, Robert H. Byers, PhD, Gail Bolan, MD, John M. Douglas, Jr., MD, Patricia M. Moss, MSN, Peter D. Weller, PhD, Dan Joy, MSW, Brad N. Bartholow, MA, and Janet S. Harrison, MA
Sexually Transmitted Diseases, July - September 1991; 18(3): 170-175

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• 198 gay/bi men in SF who were at least 18 yrs. • Reported oral/anal sex in previous 4 mos. • Self-administered questionnaire • Standardized interview	• Mean age: 34 Age range: 18 - 75 • Race: 60% - white 16% - black 21% - Latino/Hispanic • Education: <High School (9%) HS grad only (58%) College grad (33%)	• 69% - unprotected anal sex • 55% - unprotected oral sex w/ejaculation • 18% - unprotected oral sex w/out ejaculation • # of non-steady partners - (med. = 3) # of steady partners (med. = 1)	•17% - IDU (4 mos.-any use) 84% - Alcohol 61% - Marijuana 31% - Cocaine 55% - 3 or more drugs	• Predictors of unprotected anal intercourse of men not in monogamous relationship: • Age at first sex • High drug use • Not being a gay organization member • Hispanic bisexual • In SF: Men who were members of gay organizations less likely to engage in higher levels of unprotected anal sex. Men who began sexual activity with men at a younger age more likely to engage in unprotected anal sex. Hispanic and black participants at all sites were at higher relative risk relative than white participants.	• Many risk-reduction programs that currently focus on reaching homosexually identified as opposed to homosexually behaving men may be ineffective in reaching minority men. • Membership in a gay organization had a positive influence on men. Such membership may reinforce social norms for safer sex.	• Men who have been unable to initiate vs.. maintain behavior change were not identified. • Results from cross-sectional and longitudinal analyses predicting level of risky behavior may differ considerably.

Relapse From Safer Sex: The Next Challenge for AIDS Prevention Efforts.
Stall R; Ekstrand M; Pollack L; McKusick L; Coates TJ.
Journal of Acquired Immune Deficiency Syndromes, 1990, 3(12):1181-7.

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• 397 men who were followed consistently from 1984 to 1988 (8 waves of data collection).		• 76% decline in high-risk sexual behavior (unprotected anal intercourse) from '84 to '88. • 69% of high-risk sex in 1988 wave characterized as relapse. • Predominant form of high-risk sex from relapse rather than from consistent high-risk sex.		• Unprotected anal intercourse as a favorite sexual activity (men at low risk). • Social support for taking health risks (men at low risk). • Being in love (monogamous). • Having the same serostatus as partner (monogamous). • Being sexually aroused (non-monogamous) • Sex and alcohol/drugs (non-monogamous) • Lack of condom availability (non-monogamous)		

High-Risk Sexual Behavior and Knowledge of HIV Antibody Status in the San Francisco City Clinic Cohort
Lynda S. Doll, Paul M. O'Malley, Alan L. Pershing, William W. Darrow, Nancy A. Hessol, Alan R. Lifson.
Health Psychology, 1990; 9(3): 253 - 265

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• 309 cohort members in this study were men meeting the criteria for inclusion in cohort AIDS studies conducted between October 1986 and December 1987. • All participants interviewed by trained staff using standardized questionnaires.	• Mean age - 37 yrs. • White (92.6%) Black (2.9%) Hispanic (3.2%) • 15.6 average years of education. • 181 learned their serostatus prior to interviews. • 129 agreed to be tested but chose not to learn their test results. • Seronegatives were significantly older than seropositives (Mean 38 yrs. vs.. Mean 35 yrs.)	• Seropositives had higher baseline risk indices than seronegatives - regardless of whether they knew their HIV status. (RAI w/ non-steady partners) • Both groups, regardless of whether they knew learned their HIV status, demonstrated reductions in high-risk sexual behaviors from 1983-1984 to 1986-1987.		• Seropositive men may be more likely to have sexual contacts with men they know to be seropositive and see this activity as lower risk for transmission of HIV, but w/out additional information on the serostatus of their partners, it is difficult to interpret their higher risk indices for insertive anal intercourse w/ non-steady partners.	• Knowing one's HIV status many not be a prerequisite to decreasing one's high-risk sexual behaviors.	• This is not a randomized, controlled trial of the effect of learning one's HIV status. • 75% of this cohort was infected w/HIV by 1988; watching one's friends become ill and die may account for more behavior change than learning one's HIV status. • Future evaluation research should focus on HIV testing and counseling programs aimed at heterosexual men and women and at younger, minority, homosexual and bisexual men.

Longitudinal Predictors of Reductions in Unprotected Anal Intercourse among Gay Men in San Francisco: The AIDS Behavioral Research Project
Leon McKusick, PhD, Thomas J. Coates, PhD, Stephen F. Morin, PhD, Lance Pollack, MA and Colleen Hoff
American Journal of Public Health August, 1990; 80(8): 978-983

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• Subjects for the AIDS Behavioral Research Project were recruited initially in 1983 and 1984 at bath houses and bars and by advertising for individuals who were in committed relationships or who did not use bars or baths. • A total of 754 men were enrolled in the sample in 1984, representing 51 percent of those approached to participate. • Subjects were mailed a self-administered questionnaire each November, and asked to complete the questionnaire and return it by mail to the investigators. • Data reported here are for 508 men who returned every questionnaire between 1984 and 1988.	• 57.7%: non-monogamous w/the same person • 9.7%: mutually monogamous w/the same person • Age ranged from 19 to 63 with a mean of 35.7 • 77% of the sample help professional or white collar occupations • 91% were Caucasian • 68% had attended some college • Mean annual income was $24,000.	• Reduction in unprotected anal intercourse: 49.8% in 1984 to 12% in 1988. • Increase in protected anal intercourse: 15.2% in 1984 to 23.8% in 1988. • Monogamous men were more likely to practice unprotected anal intercourse in 1984 and in 1988. • Monogamous men, compared to non-monogamous men, were more likely to report in 1984 that unprotected anal intercourse was their favorite sexual activity, to be above the median in self-efficacy, and less likely to believe they were exposed to HIV.		• Unprotected anal intercourse for non-monogamous men: • those who were younger • who reported their favorite sexual activity was unprotected anal intercourse • who were lower in personal efficacy • who were less depressed • Monogamous men who practiced unprotected anal intercourse in 1984 but did not practice it in 1988 were more likely to have been diagnosed as HIV antibody positive, while those who tested antibody negative were more likely to continue the practice.	• Risk reduction programs may need to eroticize alternative sexual practices, promote skills that increase self-efficacy, modify social norms supporting high-risk behavior, and encourage antibody testing so that seropositive individuals are further reinforced to reduce sexual behaviors likely to infect others with HIV.	• The study includes predominantly White gay males who are educated and living in San Francisco. • Missing from this analysis were data regarding alcohol and drug usage, and their relationship to high-risk sex.

A Survey of AIDS Knowledge, Attitudes and Behaviors in San Francisco's American-Indian, Filipino and Latino Gay and Bisexual Male Communities. Prepared for the San Francisco Department of Public Health, AIDS Office by Fairbank, Bregman & Maulin, Inc. May 15, 1991.

1. Summary of Results: American-Indian Gay/Bisexual Male Survey

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• Chain-referral, convenience sample. Respondents located at clubs, gay bars, health agencies, etc. • 60 interviews conducted among American Indian respondents. • 106 interviews conducted among Filipino respondents. (Filipino respondents were given the option of completing the interview in Tagalog or English.) • 100 interviews conducted among Latino respondents. (Latino respondents were given the option of conducting the interview in Spanish or English.) • Interviewing was conducted during the period June through October, 1990.	• 40%: raised on a reservation or mostly Indian community. • Age range (%): 30-34: 50% 35-39: 23% 25-29: 18% • Education: Not HS grad: 7% HS grad: 43% Some college or vocational school: 38% College grad/professional school: 9% • <$10,000: 60% $10,000 to $20,000: 27% Currently unemployed: 68% • Gay identified: 90% Bisexual: 2% Straight: 2%	• 20%: reported unprotected anal intercourse with a male partner. • 73%: reported using condoms only sometimes. • 68%: report having difficulty in talking about condoms with their sexual partners.	• 13%: reported sex under the influence of alcohol or another drug. • 27%: reported marijuana use. • 2%: reported injecting cocaine and speed or some other amphetamine.		• Gay men of color hear and see the information disseminated in the majority community, but do not necessarily respond to it. Community groups which serve the gay and bisexual American-Indian, Filipino and Latino communities are more likely to have the respect and trust of the people they serve. • In the American Indian community, there is a disproportionately high number of unemployed, poor and homeless gay and bisexual men. Community groups providing assistance to these people can be conduits for AIDS prevention information. • Rather than a "macro" approach to advertising using mass media, a "micro" approach, reaching people through the smaller and thus far underutilized, personal, community-centered organizations is recommended.	

2. Summary of Results: Filipino Gay/Bisexual Men

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• Chain-referral, convenience sample. Respondents located at clubs, gay bars, health agencies, etc. • 60 interviews conducted among American Indian respondents. • 106 interviews conducted among Filipino respondents. (Filipino respondents were given the option of completing the interview in Tagalog or English.) • 100 interviews conducted among Latino respondents. (Latino respondents were given the option of conducting the interview in Spanish or English.) • Interviewing was conducted during the period June through October, 1990.	• 8%: lived in US < 3 years. 22%: four to nine years 45%: ten years 25%: born/raised in US • <u>Age range(%)</u> 18 to 29: 42% 30 to 34: 23% 35 to 39: 16% 40 to 44: 16% • 55%: grad. from a college or prof. school 32%: some college/ prof. school 10%: high school grad. 2%: non HS grad. • <$10,000: 15% $10,000 to $20,000: 25% $20,000 to $30,000: 19% $30,000 to $40,000: 19% >$40,000: 11%	• 34%: reported unprotected anal intercourse with a male partner. • 62%: reported not always using condoms. • 68%: reported difficulty in talking about condoms with their sexual partners.	• 42%: reported sex under the influence of alcohol or another drug. 36%: of these less likely to use a condom when "under the influence." • 33%: reported marijuana use. • 9%: admitted to injecting some drug in the past year, one injecting an hallucinogen, two cocaine and seven injecting vitamins. • 6 of 10 respondents who used a needle for injecting drugs did not know how to clean and disinfect a needle in order to kill the AIDS virus.		• Community organizations which are more in tune with gay and bisexual men who were not born and/or raised in the US would be more likely to "speak the language" of the target group than would an organization that serves a more general Filipino or Latino population. • Informal networking using established settings, such as gay bars that have a predominantly Latino or Filipino clientele, gay Filipino or Latino social organizations, and any other place where gay men of color gather on an informal basis are good locations to disseminate information.	

3. Summary of Results: Latino Gay/Bisexual Male Survey

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• Chain-referral, convenience sample. Respondents located at clubs, gay bars, health agencies, etc. • 60 interviews conducted among American Indian respondents. • 106 interviews conducted among Filipino respondents. (Filipino respondents were given the option of completing the interview in Tagalog or English.) • 100 interviews conducted among Latino respondents. (Latino respondents were given the option of conducting the interview in Spanish or English.) • Interviewing was conducted during the period June through October, 1990.	• <u>Age range (%)</u> 18 to 30: 56% 30 to 39: 32% 40 + : 12% • >HS: 24% HS grad: 28% Some college/ business or vocational: 29% College grads: 18% • <$10,000: 61% $10,000 to $20,000: 28% Currently unemployed: 62% • 27%: lived in US <3 years. 20% live in US 4 to 9 years. 32%: live in US for 10 years. 20%: born and raised in US. • Gay identified: 65% Bisexual: 23% Queena: 10% Transsexual: 1% Straight: 1%	• 47%: reported unprotected anal intercourse with a male partner, at least once, during the preceding 12 months. • 46%: said that condoms are not necessary when they have just one partner. • 50%: reported definite "at-risk" sexual behavior.	• 60%: under the influence of alcohol, marijuana, cocaine or some other drug during sexual activity. 30%: of these less likely to use a condom. • 10%: admitted to injecting some drug in the past year. • 7 of the 10 respondents who used a needle for injecting a drug did not know how to clean and disinfect a needle in order to kill the AIDS virus. • 3 respondents had shared a needle in the previous year.		• Gay men of color hear and see the information disseminated in the majority community, but do not necessarily respond to it. Community groups which serve the gay and bisexual American-Indian, Filipino and Latino communities are more likely to have the respect and trust of the people they serve. • In the American Indian community, there is a disproportionately high number of unemployed, poor and homeless gay and bisexual men. Community groups providing assistance to these people can be conduits for AIDS prevention information. • Rather than a "macro" approach to advertising using mass media, a "micro" approach, reaching people through the smaller and thus far underutilized, personal, community-centered organizations is recommended.	

HIV-Related Knowledge, Attitudes, and Behaviors Among San Francisco's Gay and Bisexual Men: Results from the Fifth Population Based Survey. Communication Technologies, Inc., SFDPH AIDS Office, San Francisco AIDS Foundation. January 31, 1990

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• The survey was conducted by telephone among a random-digit-dial sample of 401 San Francisco households composed of one or more openly homosexual/bisexual men. • One randomly selected adult gay male within the household was interviewed. • Interviews were conducted between October 11 and December 5, 1989.	• As with previous studies, respondents tended to be overwhelmingly white, mid-30's in age, and highly educated. They tended to report up-scale incomes and occupations. They tended to be renters rather than homeowners. Their residences are located in all parts of the city.	• Approximately three-in-ten respondents report engaging in unprotected anal intercourse, oral-to-anal contact, fisting, or oral sex with semen exchange within the 30 days prior to the interview. • Oral sex involving the exchange of semen, and oral-to-anal contact have increased. • Over the past year, 18% of respondents reported engaging in unprotected anal intercourse. • 16% of respondents can be classified as relapsers, men who made a commitment to never practice unprotected anal sex but did so in the last year.	• 7% are frequent and heavy users of alcohol • 21% are heavy users of drugs such as marijuana, cocaine, speed, or nitrate inhalants • 4 in 10 have either sought treatment, considered it, or believe they have a substance-use-related problem • 1 in 10 have used needle-injection drugs at some point in their lives	• The following segments of the population were more likely than the population as a whole to report unsafe sex practices: • New residents, particularly less than 2 years • Respondents w/incomes less than $15,000 • Heavy drug users • Those who have used needle-injecting drugs at some point in their lives • Those in primary relationships w/other men • Those who have not taken the AIDS antibody test • Those who report combining substance use with sex		• The relatively high educational level and low use of injectable drugs observed suggests that the three racial groups analyzed may not be representative of the general population.

LESBIAN AND BISEXUAL WOMEN

Published Behavioral Studies:

1. Assessing Risk in the Absence of Information: HIV Risk Among Women Injection-Drug Users Who Have Sex with Women.
   Young RM, Weissman G, Cohen JB
   AIDS & Public Policy Journal, 1992; 175-183

2. HIV Seroprevalence and Risk Behaviors Among Lesbians and Bisexual Women.
   SFDPH, AIDS Office, October 1993

KABB Behavioral Summaries:

3. Health Behavior Among Lesbian and Bisexual Women: A Community-Based Women's Health Survey, SFDPH, AIDS Office, October 1993

LESBIAN AND BISEXUAL WOMEN

Behavioral Summary

Because the risk of woman-to-woman HIV transmission is thought to be lower than transmission via same gender sex between men or sex between men and women, lesbians have traditionally been thought of as a very low risk group. Similarly, because bisexual women are combined with lesbian women (woman-to-woman sexual transmission is usually the factor that differentiates both groups from heterosexual women), they are also considered low risk.

Despite the hierarchical, mutually exclusive categories that are used to report risk of infection for women, a pattern of increased HIV infection risk among lesbian and bisexual women (especially those who inject drugs) is emerging from initial seroprevalence and behavioral research. Such results indicate that high levels of unprotected sex with gay/bisexual men and injection drug use warrant specific interventions targeting this population.

In 1993, the San Francisco Department of Public Health conducted a Seroprevalence and Risk Behavior study of lesbian and bisexual women in San Francisco and Berkeley. This study found that the prevalence in the surveyed population was more than three-fold higher than that estimated for all adult or adolescent women in San Francisco. Lesbian and bisexual women in this survey reported very high levels of unsafe sexual behaviors with men and women (including unprotected sex with gay/bisexual men, sex workers and IDUs). In addition, injection drug use was high in this population and 70% shared needles (31% reported sharing with gay/bisexual men). All of the seropositive women had a history of either injection drug use or sex with men.

The San Francisco Department of Public Health also conducted a Health Behavior survey of lesbian and bisexual women and found that although lesbian women were more likely than bisexual women to have had sex with only women, 22% reported having sex with both men and women and 3% with just men in the past 3 years. Thirty four percent of bisexuals and 5% of lesbians reported having sex with a gay or bisexual man in the past three years. Overall, 12% of the sampled population had sex with a woman who has injected drugs and 5% with a man who injects.

Project AWARE in San Francisco found that women who had sex with one or more women since 1980 were nearly twice as likely to inject drugs during

the same time period as women who had no female sexual partners. Similarly, twice as many women who identified as either exclusively lesbian or as bisexual had engaged in anal intercourse with a male partner during the last three years.

Recommendations for Prevention

The negation of risk by virtue of lesbian or bisexual identity will only hamper HIV prevention. HIV prevention which targets women should better understand and address the needs of lesbian and bisexual women. Health care providers need to be sensitive to the specific needs of lesbian and bisexual women (this may entail training in sexuality and HIV prevention).

To assume that lesbians are not engaging in sex with men (especially gay, bisexual or injection drug using men) may mean overlooking behaviors that initial research has shown to be fairly common. Furthermore, the high percentage reporting injection drug use indicate that many IDUs who self-identify as lesbian or bisexual may not be being reached by interventions that were created for heterosexual IDUs and their partners or women in general. Programs for IDUs must develop materials that explicitly address lesbian and bisexual IDUs, stressing the data that suggest increased HIV risk and the importance of reducing risk from both drug-using and sexual behaviors.

Subsets of women meeting a behavioral definition of lesbian/bisexual may be at risk for different reasons and may need to be reached by different education and outreach strategies. Specific programs should also be developed for reaching young lesbian and bisexual women.

Recommendations for Future Research

Future studies of HIV risk must consciously seek to collect relevant information about lesbian and bisexual women, especially those who inject drugs. Targeted research should describe and assess the HIV risk behaviors in which lesbians and bisexuals and lesbian/bisexual IDUs engage. Such research should include samples of young women and different racial/ethnic groups.

Just as bisexual men are usually combined with gay men in many research studies, lesbian and bisexual women are usually described together. Future research should explore any if there are any behavioral differences between lesbian and bisexual women. Although longer time periods (i.e., 3 years) are needed to assess history of sexual activity with men, future research should use more recent time periods as well.

HIV Seroprevalence and Risk Behaviors Among Lesbians and Bisexual Women:
The 1993 San Francisco/Berkeley Women's Survey
SFDPH, AIDS Office, October 1993

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross sectional survey • Jan-Aug 1993 • 550 women were randomly surveyed from 25 venues (places where lesbians and bisexual women congregate) in SF and Berkeley • 17 yrs and older • Response rate = 69% • Interview and blood draw took place in van parked near the sampling venue	• 68% self identified as lesbian, 22% as bisexual, 4% as heterosexual and 7% undecided • 60% were in their 20s and 30% were in their 30s. Only 4% were between 17 and 19 • 17% Afr-Amer • 12% Asian/PI • 15% Latina • 2% Native Amer • 54% White • 1% other • 49% had a college degree or higher degree	• Of the 405 who had sex w/ men, 15% had sex with a gay or bisexual man, 4% had sex with an IDU and 4% had sex with both gay/bi men and IDUs • Unprotected sex with men in the past 3 yrs: vaginal sex (39%) anal sex (11%) • Unprotected sex with gay/bisexual men: oral sex (15%) vaginal sex (10%) anal sex (3%) • Unprotected sex with male IDUs: vaginal sex (5%) anal sex (2%) • Among the 468 who had sex with women, 11% had sex with sex workers, 9% with IDUs and 8% with both IDUs and sex workers	• 10% reported injection drug use since 1978 • Of those who injected since 1978, 71% had a history of sharing needles • 31% reported sharing needles with gay/bisexual men • 4% reported injecting drugs in the past three years		• The prevalence of HIV infection in this population was more than three-fold higher than that estimated for all adult or adolescent women in SF • Many of these women were engaging in high risk sex with men and women, and need to be reached by prevention • Prevention cannot assume that lesbian women are "low" risk based only on data collected for traditional risk categories. These women were clearly engaging in high risk activities that may have been overlooked	• Sample may not be representative of Lesbian bisexual women, other than those who regularly attend the bars, dance clubs and other venues used for sampling • Behavioral data based on the past 3 years is not very specific and may introduce recall bias

Assessing Risk in the Absence of Information: HIV Risk Among Women Injection-Drug Users Who Have Sex with Women
Young RM, Weissman G, Cohen JB. AIDS & Public Policy Journal, 1992; 175-183

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• 711 women who have participated in the AWARE (Association for Women's Research and Education) project since 1988 in San Francisco	• 76% identified as heterosexual, 3% as exclusively gay and 21% preferred some combination of partners of both genders • 69% Afr-Amer • 6% Latina • 21% White • 4% other • Mean age = 32	• Twice as many women who identified as either exclusively homosexual or as bisexual had engaged in anal intercourse with a male partner during the last 3 yrs (32% vs. 16%) • Women who self identified as lesbians were more likely to be seropositive than women identifying as either bisexual or heterosexual, however, fewer women who reported only having female sexual partners since 1980 were HIV positive than women who reported having no female sexual partners	• 99.7% of women have used drugs in the past 3 years • 41% have injected • Women who had had one or more female sex partners since 1980 (329) were nearly twice as likely to inject drugs during the same time period as women who had no female partners (72% vs. 42%) • 32% have used crack cocaine		• Female IDUs who do not identify as lesbian but who do have sex with other women may be missed by programs • Different subsets of women meeting a behavioral definition of lesbian/bisexual IDUs may be at risk in different ways and can be reached by different outreach and education strategies • It is important to separate sexual identity and sexual behavior when designing programs • Prevention messages may be inappropriate for many lesbians and bisexual women, they should address lesbian and bisexual IDUs, stressing the data that suggest increased HIV risk and the importance of reducing risk from both drug using and sexual behaviors	• Non-random sample • Small sample size

Health Behavior Among Lesbian and Bisexual Women: A Community-based Women's Health Survey
SFDPH, AIDS Office, October 1993

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross sectional survey (interview) • 1992 • 483 interviews were conducted with a convenience sample • Entry criteria: being at least 18 years old and self-identifying as a woman who has sex with other women • Recruitment: street and community locations in SF (sample is of socially active lesbian & bisexual women). • $30 payment • 760 women were eligible; 674 agreed to participate, 483 completed interview • Response rate = 64%	• 11% Afr-Amer • 9% Asian/PI • 11% Latina • 64% White • Native Amer / Mixed • Mean age = 31 yrs • 61% had a college degree or higher and only 16% were unemployed • 40% reported child-hood sexual abuse	• 98% were sexually active in past 3 yrs • 60% had sex only with women, 5% had sex only with men and 33% had sex with both • 22% of self identified lesbians had sex with both men and women and 3% w/ just men • 71% of self-identified bisexuals had sex with both men and women, 12% with men only and 12% with women only • 12% had sex w/ a women who has used injection drugs and 5% with a man who injects • 34% of bisexuals and 5% of lesbians reported having sex with a gay or bisexual man in the past 3 yrs. • Unprotected sex was more common with primary partners than secondary partners (regardless of partner's gender) • 59% reported sharing toys with female partner, but 61% of this group washed it	• 23% reported intravenous drug use in the past 3 years • 73% used at least one illicit substance in the past 3 yr. • 82% drink alcohol at least a few times a year (53% have 2 or 3 drinks at one time & 10% have four or more drinks) • 70% said they have been high on alcohol or other drugs during sex in the past 3 years		• HIV prevention which targets women should better understand and address the needs of lesbian and bisexual women. • If providers assume that lesbians are not engaging in sex with men (especially gay, bisexual and IV drug using men, they will be overlooking risk behaviors that this survey has shown to be fairly common • How women self-identify and their sexual behaviors are often not the same	• Convenience sample from places where it is likely that lesbian and bisexual women will be limits generalizability • Recent sexual behaviors were not asked. Three & even 1 year time frame makes recall difficult and behaviors very general.

HETEROSEXUAL MEN AND WOMEN

Published Behavioral Studies:

1. Factors Associated With Condom Use in a High-Risk Heterosexual Population.
Hillard S. Weinstock, MD, Christina Lindan, MD, Gail Bolan, MD, Susan M. Kegeles, PhD, and Norman Hearst, MD, PhD
Sexually Transmitted Diseases, 1993; 20(1): 14-20

2. Demographic Characteristics of Heterosexuals with Multiple Partners: The National AIDS Behavioral Surveys.
M. Margaret Dolcini, Joseph A. Catania, Thomas J. Coates, Ron Stall, a
S. Hudes, John H. Gagnon and Lance M. Pollack
Family Planning Perspectives, 1993; 25(5): 208-214

3. Patterns of Sexuality in a High-Risk Sample: Results from a Survey of New Intakes at a County Jail.
Mark T. Temple, PhD
Archives of Social Behavior, 1993; 22(2):111-129

4. HIV risk-related sexual behaviors among heterosexuals in New York City: associations with race, sex, and intravenous drug use.
Mimi Y. Kim, Michael Marmor, Neil Dubin, and Hannah Wolfe
AIDS 1993; 7(3):409-414

5. Condom Use in Multi-Ethnic Neighborhoods of San Francisco: The Population-Based AMEN (AIDS in Multi-Ethnic Neighborhoods) Study.
Joseph A. Catania, PhD, Thomas J. Coates, PhD, Susan Kegeles, PhD, Mindy Thompson Fullilove, MD, John Peterson, PhD, Barbara Marin, PhD, David Siegel, MD, MPH, and Stephen Hulley, MD, MPH
American Journal of Public Health, February 1992;82(2):284-287

6. Risk for AIDS in multiethnic neighborhoods in San Francisco, California. The population-based AMEN Study.
Fullilove MT; Wiley J; Fullilove RE 3d; Golden E; Catania J; Peterson J; Garrett K; Siegel D; Marin B; Kegeles S; et al.
Western Journal of Medicine, 1992 Jul, 157(1):32-40.

7. Correlates of HIV risk behaviors in black and white San Francisco heterosexuals: the population-based AIDS in multiethnic neighborhoods (AMEN) study.
Peterson JL; Grinstead OA; Golden E; Catania JA; Kegeles S; Coates TJ.
Ethnicity and Disease, 1992 Fall, 2 (4) : 361-70.

8. Changes in Sexual Practices Over 5 Years of Follow-Up Among Heterosexual Men in San Francisco.
Michael C. Samuel, Joseph Guydish, Maria Ekstrand, Thomas J. Coates, and Warren Winkelstein, Jr.
Journal of Acquired Immune Deficiency Syndromes, 1991; 4(9):896-900, 1991

9. Sexual Risk for HIV Transmission among Singles-Bar Patrons in San Francisco.
Ron Stall, Suzanne Heurtin-Roberts, Leon McKusick, Colleen Hoff, Sylvia Wanner Lang
Medical Anthropology Quarterly, March 1990; 4(1)(NS):115-128

Women Only Studies

Published Behavioral Studies:

10. Sexual Risk for Human Immunodeficiency Virus Infection Among Women in High-Risk Cities.
Grinstead OA, Faigeles B, Binson D, Eversley R
Family Planning Perspectives, 1993; 25: 252-256

11. Sexual Risk and Perception of Risk for HIV Infection Among Multiethnic Family Planning Clients.
Eversley RB, Newstetter A, Avins A, Beirnes D, Haynes-Sanstad D, Hearst N
American Journal of Preventive Medicine, 1993; 9(2): 92-95

12. AIDS Knowledge and Risk Behaviors Among Culturally Diverse Women.
Harrison DF, Wambach KG, Byers JB, Imershein AW, Levine P, Maddox K, Quadagno DM, Fordyce ML, Jones MA
AIDS Education and Prevention, 1991; 3(2):79-89,

KABB Behavioral Summaries:

13. Results from PHREDA Projects
KABB Surveys Conducted in 1993 and 1994
(Cares Project of High Risk Women)

14. Results from PHREDA Projects
KABB Surveys Conducted in 1993
Samples from 4 Public Housing Project

HETEROSEXUAL MEN AND WOMEN

Behavioral Summary

Heterosexual men and women in the United States have consistently been viewed as a population not at significant risk of infection with the AIDS virus. Since the disease was first identified among and strongly associated with gay and bisexual men and injection drug users in this country, heterosexuals have not been studied as intensively or systematically as these other populations. Adding to the problem is the conservative climate which surrounds sexuality in the United States. The federal government has repeatedly blocked efforts to study the sexual behaviors of heterosexual adults in the United States, and as a result, prevention programs targeting this group are based largely on assumption and out of date behavioral data.

In San Francisco, several studies indicate that heterosexual men and women were less likely to use condoms if they were black or Hispanic. Women who perceived difficulties in exerting control over the use of condoms, regardless of racial/ethnic identification, were less likely to use them. The study also found that black and Hispanic women were less likely than white women to have sexual partners who always use condoms.

A common predictor of high-sexual risk taking among heterosexuals is drug-using behaviors. In one study, injection drug users reported higher rates of sexual risk behaviors than the rest of the population being studied. The same study also found that having a sex partner who used injection drugs was a predictor of high-sexual risk taking.

Finally, common across studies is the perception that condoms are a barrier to pleasurable sexual experience and interfere with intimacy and trust between a man and a woman. One study found that both men and women reported they would not use a condom if they were in love with their partner. All studies reviewed showed that condom use was lower with main partners.

Recommendations for Prevention

Educational efforts that stress men's responsibility for using condoms and that help women develop skills to negotiate their use are necessary. In addition, strategies that convince men and women that they may be at risk even in a primary relationship are urgently needed.

Gender differences in multiple relationships are influenced by culture and marital status, creating a situation in which men and women are at risk for different reasons. HIV/AIDS prevention messages may need to be tailored in different ways for men and women and must also be tailored to specific cultural subgroups. Interventions must also take into account gender differences in the meanings that condoms and sexual assertiveness have for sexual partners.

Messages that have been typically aimed at women, including reducing the number of partners, monogamy, and use of condoms must now be directed to men. These messages have not taken into account the realities of women's lives and have placed the burden of preventive behaviors on them alone. To make condom use the norm, heterosexual men and women must also be taught the social skills necessary to negotiate with a partner and to refuse sex with someone who will not use a condom. However, these strategies will be ineffective if cultural mores, norms, and values are not considered during the development stage.

Recommendations for Future Research

The most critical area of behavioral research for heterosexual men and women revolves around cultural identification and cultural norms. Research must be conducted that uncovers the cultural motivations of sexual behaviors for both men and women. Future evaluation research should also evaluate gender specific interventions.

Factors Associated With Condom Use in a High-Risk Heterosexual Population.
Hillard S. Weinstock, MD, Christina Lindan, MD, Gail Bolan, MD, Susan M. Kegeles, PhD, and Norman Hearst, MD, PhD
Sexually Transmitted Diseases • January - February 1993; 20(1): 14-20

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• 300 heterosexuals enrolled in a cross-sectional study of patients attending San Francisco's only public sexually transmitted disease clinic from October 1 to December 31 1989. • Reported having sex with a member of the opposite gender	• Gender: Men: n = 136 Women: n = 164 • Mean age: Men: 29 Women: 27 • Race/Ethnicity (%) <u>Men:</u> Black (43) Hispanic (15) White (35) Other (8) <u>Women:</u> Black (45) Hispanic (6) White (40) Other (9) • <u>History of IV drugs (%)</u> Men: (10) Women: (18) <u>History of "crack" (%)</u> Men: (32) Women: (35) <u>Received money/drugs for sex (%)</u> Men: (5) Women: (16) • 51% men and 64% women reported having had an STD in the past • 37% men and 48% women reported that their steady sex partners had definitely or possibly had sex with someone else during the previous 2 months.	• Patients engaged in vaginal, oral, and anal sex in the previous 2 months. • 31% men no more likely to use condoms more than half the time w/casual or steady partners. • 26% women more likely to use condoms more than half the time w/ casual and steady partners. • 97% of all patients reported having used a condom at least once in the past.	• Men more likely to have used drugs or alcohol w/sex more than half the time w/their casual partners than w/ their steady partners. • Same for women	• Men were less likely to use condoms if they were black or Hispanic, reported using alcohol or drugs at last intercourse, stated that they would not use a condom if they were in love with their partners, reported difficulty communicating with their partners about condoms, or stated that their partners did not want to use condoms. • Women were less likely to use condoms if they were black or Hispanic, stated that condoms decrease sexual pleasure, reported that they would not use a condom if they were in love with their partners, or stated that their partners did not want to use condoms. • Women who perceived barriers to using condoms or difficulties exerting control over their use, lack of self-efficacy also less likely to use them.	• Efforts to increase condom use should especially target black and Hispanic patients. • Educational efforts that stress men's responsibility for using condoms and that help women develop skills to negotiate their use are necessary. • Strategies to convince men and women that they may be at risk even in their primary relationships. • Because of the prevalence of drug use among STD clinic patients, messages addressing safe sex should include warnings about the use of drugs and alcohol with sex.	• Use of an STD clinic population as the sample.

Demographic Characteristics of Heterosexuals with Multiple Partners: The National AIDS Behavioral Surveys.
M. Margaret Dolcini, Joseph A. Catania, Thomas J. Coates, Ron Stall, Esther S. Hudes, John H. Gagnon and Lance M. Pollack
Family Planning Perspectives, 1993; 25(5): 208-214

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• Interviews w/ 10,630 people aged 18-75 from June 1990 and February 1991. • Two overlapping samples: a national sample and a "high risk cities" sample. • Weights were applied to adjust the samples for unequal probabilities of selection and nonresponse.	High-Risk Cities Sample (Weighted): • Gender: Men: 4, 318 Women: 3, 923 • Race/Ethnicity (%): Black: (22.6) Hispanic: (13.5) White: (59.2) Other: (4.7) • Age (%): 18-29: (31) 30-39: (24.1) 40-49: (15.9) 50-59: (11.8) ≥ 60: (17.1)	• Number of sexual partners: 9% of national sample/12% of high-risk cities sample report multiple partners in the previous 12 mos. • Younger, male, unmarried more likely to have multiple partners. • Condom Use: For people w/ two or more partners, 51% never used condoms w/ their primary partners, and 40% never did w/ their secondary partners.		• Multiple sexual relationships strongly associated w/gender, age, and marital status.	• Gender differences in multiple relationships are influenced by culture and marital status, creating a situation in which men and women are at risk for different reasons. • Messages may need to be tailored in different ways for men and women. • Prevention messages need to be tailored to specific cultural subgroups.	• Caution should be used in generalizing national findings to smaller geographic areas.

Patterns of Sexuality in a High-Risk Sample: Results from a Survey of New Intakes at a County Jail
Mark T. Temple, PhD
Archives of Social Behavior, 1993; 22(2): 111-129

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• Survey of new arrestees at the Main Detention Facility for Contra Costa County. • 70% of intakes chosen were successfully interviewed. (n = 1104)	• Gender: Male: 83% Female: 17% • Median age: 27 • Ethnicity: White: 58% Black: 31% Hispanic: 10% Other: 1% • Mean years of education: 12.5	• 95% of sample currently sexually active • Half of respondents reported having two or more sexual partners in the last year • Respondents not currently in a primary relationship reported having intercourse less frequently than respondents who are currently in a primary relationship • Respondents in primary relationships less likely to use condoms • Non monogamous respondents were more likely than monogamous respondents to use condoms during anal intercourse	• Drinking patterns: At least once a year: 88% Daily: 22% 5+ drinks per occasion: At least once a week: 29% • Drug use (used drugs past year): 73% • Type of drug use: Crank/ methamphetamine: 31% Crack/cocaine: 30% Marijuana: 53% Sedatives: 11% Heroin/methadone: 11% Other: 17%		• Majority of individuals in the sample were non monogamous and few consistently used condoms suggesting that individuals coming in contact w/ the criminal justice system might be in particular need of AIDS prevention and education efforts.	• These data are only from one county and are not representative of new arrestees at all jails in the nation. • Certain types of cases were purposely not sampled in this investigation. • The interviews were conducted during a stressful period in these people's lives.

HIV risk-related sexual behaviors among heterosexuals in New York City: Associations with race, sex, and intravenous drug use.
Mimi Y. Kim, Michael Marmor, Neil Dubin, and Hannah Wolfe
AIDS 1993; 7(3): 409-414

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• Subjects were recruited from Bellevue Hospital Center, New York City between 1986 and 1989, and interviewed about sexual behaviors and intravenous drug use. Analyses were based on 1561 black, white, or Hispanic individuals who reported having sexual contact with a member of the opposite sex.	• Gender: Male: n=547 (35%) Black: 29% Hispanic: 33% White: 39% Female: n=1014 (65%) Black: 26% Hispanic: 48% White: 26% • Overall, whites were the most likely, and Hispanics the least likely, to have had 12 or more years of education. • Hispanics were the most likely to be married, and the least likely to have used IDs. • The age distribution between ethnic groups was similar for men, while black women tended to be younger and white women older. • After adjusting for ethnicity, men and women differed only in marital status: women were more likely to be married than men.	• The prevalence of sex with an intravenous drug user and anal sex were high in all ethnic/sex groups. • Black men more likely than white men to have initiated sexual intercourse by age 15, to have had at least 10 partners in the previous 5 years, to have been diagnosed with syphilis and gonorrhea. • Hispanic men more likely than white men to have had sex with a female prostitute. • Black women were more likely than white women to have had intercourse by the age of 15, to have a history of syphilis and gonorrhea. Less likely to have had 10 or more partners and non-condom partners, and anal and oral intercourse. • Hispanic women less likely to have had 10 or more partners, and to have had sex with an IDU than white women. • A high proportion of women reported sexual contact with an IDU.	• 10% of men and 9% of women reported a history of intravenous drug use. ¶ IDU were more likely to engage in high-risk sexual behaviors than non-drug users.		• Continuing need to educate the public about the risk of HIV infection through heterosexual contact. • Behavioral intervention programs targeted to IDU must focus equally on changes in risky sexual behaviors and drug-injection practices. • The high prevalence of subjects who had engaged in sexual intercourse by 15 years of age emphasizes the importance of educating youths about safer sexual practices at an early age, before they become sexually active.	• Subjects were volunteers who took part in the study without compensation. • The IDU in this population were a heterogeneous group of recent, as well non-recent drug users, who may or may not have been enrolled in treatment programs. This limits the generalizability of the findings to specific subgroups of IDU. • Information was also obtained from face-to-face interviews. Some ethnic groups may be less accustomed to disclosing information about intimate sexual behaviors in this setting.

Condom Use in Multi-Ethnic Neighborhoods of San Francisco: The Population-Based AMEN (AIDS in Multi-Ethnic Neighborhoods) Study.
Joseph A. Catania, PhD, Thomas J. Coates, PhD, Susan Kegeles, PhD, Mindy Thompson Fullilove, MD, John Peterson, PhD, Barbara Marin, PhD, David Siegel, MD, MPH, and Stephen Hulley, MD, MPH
American Journal of Public Health • February 1992; 82(2): 284-287

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• Household probability sample of unmarried men and women 20 to 44 years in 16 census tracts characterized by high rates of STDs and admission to drug programs; similar proportions of Black, White, and Hispanic residents; and proximity to areas of high HIV seroprevalence. 4234 households were contacted, 2755 met survey criteria, and 1770 volunteered.	• Specific Breakdown (%) (n = 1770): Men: 49.7 Women: 50.3 White: 41 African American: 26 Latino: 25 Other racial/ethnic groups: 8 • Median Income: $18,000 • 33% less than high school education • Only sexually active included (n = 1229) (%): White: 42 African American: 32 Latino: 26 Heterosexuals (%): Men: 44 Women: 47	• Unmarried heterosexuals were poor condom users. • Those w/multiple sexual partners were least likely to be using condoms. • Black and Hispanic women were less likely than White women to have sexual partners who always use condoms.	• Findings are limited in that the results are based on cross-sectional design - authors unable to estimate condom use levels for non respondents or differentiate condom use for birth control from that for disease prevention.	• Sexual communication skills are a key influence on condom use across social strata. • Perceived effects of condoms on sexual pleasure was a consistent influence on condom use across social strata.		• Results based on a cross-sectional design, and unable to estimate condom use levels for non respondents or differentiate condom use for birth control from that for disease prevention.

Risk for AIDS in multiethnic neighborhoods in San Francisco, California. The population-based AMEN Study. Fullilove MT; Wiley J; Fullilove RE 3d; Golden E; Catania J; Peterson J; Garrett K; Siegel D; Marin B; Kegeles S; et al. Western Journal of Medicine, 1992 Jul, 157(1):32-40.

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• Target population defined as: currently unmarried men and women, aged 20-44 at initial contact, living in 16 census tracts of San Francisco. • Tracts characterized by: -high rates of reportable sexually-transmitted diseases among women -high rates of admission to drug detox programs -roughly equal numbers of black, white and Hispanic residents. • 4234 households were contacted, 2755 met survey criteria, and 1770 volunteered.	• Gender: Men (%): 77.0 Women (%): 78.0 • Age: Men: White: 397 Black: 167 Hispanic: 240 Other: 76 Women: White: 339 Black: 289 Hispanic: 195 Other: 67 • Income: $0-5,999: 414 $6-17,999: 664 $18-29,999: 442 $30-49,999: 194 $50,000 +: 45 • Education: Less than HS: 246 HS Grad: 374 Some College: 650 College Degree: 307 Postgraduate: 181	• Homosexually active men and injection drug users reported higher rates of all the other risk behaviors than the rest of the population. • One or more risk behaviors in the past year: • lowest among Hispanic women (5%) • highest among white women ((21%) • The study shows that HIV infection in SF has occurred predominantly among homosexually-active men, secondarily among injection drug users, and hardly at all in the rest of the population. • Prevalence of risk behaviors across race/gender subgroups of people who are neither homosexually-active men nor injection drug users ranges from 5% to 21%.		• Having a sex partner who used injection drugs. • Having unprotected sex w/ more than four partners in the past year. • Among women, having a homosexually active male partner.	• Prevention efforts need to be redoubled among individuals who engage in risk behaviors and who fail to perceive (or who deny) the degree to which they are at risk.	• These behavioral data underestimate true levels of risk behavior. -some may under-report behaviors they perceive to be embarrassing. -some may not be aware of their risk status.

Correlates of HIV risk behaviors in black and white San Francisco heterosexuals: the population-based AIDS in multiethnic neighborhoods (AMEN) study.
Peterson JL, Grinstead OA, Golden E, Catania JA, Kegeles S, Coates TJ
Ethnicity and Disease, 1992 Fall, 2 (4): 361-70.

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• Target population defined as: currently unmarried men and women, aged 20-44 at initial contact, living in 16 census tracts of San Francisco. • Tracts characterized by: -high rates of reportable sexually-transmitted diseases among women -high rates of admission to drug detox programs -roughly equal numbers of black, white and Hispanic residents. • 4234 households were contacted, 2755 met survey criteria, and 1770 volunteered.	• Gender: Men: n = 320 Women: n = 396 • Mean Age (years): Men: 30.4 Women: 30.5 • Race (%): MEN: White: (49) Black: (80) Hispanic: (82) WOMEN: White: (42) Black: (39) Hispanic: (19) • Income (%): MEN: < 12,000: (35) 12-39,999: (55) 40+: (10) WOMEN: < 12,000: (43) 12-39,999: (51) 40+: (6)			• Consistent condom use is related to: -labeling one's past sexual behavior as "risky" for HIV transmission -perceiving condoms as enhancing or at least not interfering with one's sexual enjoyment -having a strong commitment to use condoms -having good sexual communication skills	• Interventions that focus on condom enjoyment, social skills training, and commitment issues may not be sufficient to increase condom use w/out also taking into account gender differences in the meanings that condoms and sexual assertiveness have for sexual partners.	• Did not examine social norms, social support, and help-seeking contingencies, which have been hypothesized to influence problem labeling, condom commitment, and condom use.

Changes in Sexual Practices Over 5 Years of Follow-Up Among Heterosexual Men in San Francisco
Michael C. Samuel, Joseph Guydish, Maria Ekstrand, Thomas J. Coates, and Warren Winkelstein, Jr.
Journal of Acquired Immune Deficiency Syndromes, 1991; 4,(9): 892-900

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• San Francisco Men's Health Study: a population-based study that sampled single men aged 25 through 54 years residing in 19 census tracts of San Francisco that had the highest cumulative incidence of AIDS in 1983. • The cohort has been followed at 6 month examination cycles since the second half of 1984. • The most recent cycle w/ available data was the second half of 1989. • Data on sexual practices obtained by an interviewer-administered questionnaire. • The analyses in this report focuses on changes in sexual activity between the first and the last time periods. • 209 (20.2%) of cohort reported being exclusively heterosexual and HIV negative at the time of their first HIV test.		• This report indicates a decrease in high-risk sexual behavior among the sample. • Heterosexual men in the sample have significantly decreased their number of sexual contacts. • An increase in the use of condoms was reported.				• Difficult to generalize these findings to other populations. • Study participation may have increased AIDS awareness above that of the general population. • Some of the decrease in number of partners in the never married men may not be due to an active response to AIDS but to aging of the cohort.

Sexual Risk for HIV Transmission among Singles-Bar Patrons in San Francisco.
Ron Stall, Suzanne Heurtin-Roberts, Leon McKusick, Colleen Hoff, Sylvia Wanner Lang
Medical Anthropology Quarterly 4:1(NS), March 1990

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• August 1987: • Questionnaires distributed at 15 heterosexual bars and 12 gay bars. Self-administered questionnaires were handed out w/ a pre-addressed, stamped envelope. • Response rate: Heterosexual male: 21% Heterosexual female: 29% Homosexual men: 40% Overall rate: 30%	• 3 group distribution: less than 30 30-39 40+ • Typical age category for heterosexual men and women > 30. • Modal category for gay men 30-39.	• 1/4 of homosexual men and heterosexual women had unprotected insertive sex with a non monogamous partner. • Gay men used condoms more w/in mutually monogamous relationships than either heterosexual men or women. • During penetrative sex not in mutually monogamous relationships, gay men again used condoms more than the other two groups.		High-risk heterosexuals: • Higher AIDS concern • Higher perceived social support for reducing AIDS risk • Lower self-efficacy for reducing AIDS risk • Longer history of sexually transmitted diseases • Greater tendency to have sex under the influence of alcohol or drugs. • High-risk heterosexual males more likely to be ethnic minorities and have a formal religious affiliation.	• Bar populations include sizable proportions of persons who continue to engage in high-risk sex. • Cannot be assumed that what worked for homosexual men will work for heterosexual men and women. • Interventions will have to achieve more than educating bar patrons about the routes of HIV transmission. • Singles bars should be a place where condoms are obtained reliably and without social stigma.	

Sexual Risk and Perception of Risk for HIV Infection Among Multiethnic Family Planning Clients.
Eversley RB, Newstetter A, Avins A, Beirnes D, Haynes-Sanstad D, Hearst N.
American Journal of Preventive Medicine 1993; 9(2):92-95

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• 267 young adult female family planning clients attending Planned Parenthood clinic in SF and Oakland were surveyed between June 1989 and October 1990. • 72 item face-to-face interview was administered after the clinic appointment • response rate = 50%	• 37% Afr-Amer • 10% Asian • 11% Latina • 40% White • Median age = 24 • White women had higher education level	• 81% of the sample reported at least one risk behavior for being sexually exposed to HIV • 45% reported 2 or more risk behaviors • 53% had a history of STD infection, with • African-Americans (71%) more likely to • 35% had five or more partners in past 5 yrs • 37% had sex with partner outside of primary relationship in past year • 19% believe that primary partner may have other partners, with African-Americans (34%) being more likely to report • 35% always use condoms with outside partner • 12% always use with primary partner •12% had IDU partner		• Women w/ a history of HIV were significantly more likely to report having a non monogamous primary partner	• Prevention programs should encourage condom use with both main and outside partners • Perceived risk does not necessarily lead to risk avoidance. • HIV risk interventions may need to focus on increasing interpersonal assertiveness and risk communication skills as opposed to simple education about the behaviors that expose women to infection • Family planning and STD clinics are critical sites for the ongoing provision of culturally sensitive HIV prevention activities	• Small sample size • Many Latinas attending these clinics were younger than 18 and were ineligible for the study • Latina and Asian groups were combined into an "other" groups

Sexual Risk for Human Immunodeficiency Virus Infection Among Women in High-Risk Cities
Grinstead OA, Faigeles B, Binson D, Eversely R
Family Planning Perspectives, 1993; 25:252-256

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross sectional sample of women in 23 urban areas completed the National AIDS Behavioral Surveys • 1990-1991 • Entry criterion was being at least 18 yrs old • Phone survey, using random-digit dialing to find potential respondents • Data used in this analysis come from the highest risk cities • Respondents called from cities that had the largest number of AIDS cases and large black or Hispanic populations • 56% of Hispanics preferred to take the interview in Spanish • Response rate = 65-70% • Analyses are limited to women who reported having sex w/ men in past 5 years • African Americans and Latinas were over sampled	• 43% were younger than 30 years • 25% African-Amer • 15% Latina • 15% other • 16% had less than a high school level of education	• 89% had sex with males only in past five years • 1.3% had sex with females only and 1.7% had sex with both males and females • 15% of women reported having had multiple partners, a risky main partner (IDU, multiple partners etc.) or both. • Bisexuals reported higher risk behaviors (33% reported multiple partners in past year, 8% reported a risky male partner and 12% reported both)		• Younger women were more likely to report multiple partners • Single women were more likely to report multiple partners. • White women who had less 12 years of education and those who had more than 17 years of education were more likely to have multiple partners • Married or cohabiting Latina women were more likely than single Latina women to having risky partners • Women with a risky main partner were more likely to not use condoms	• Even among women who believed their partner was risky, were unlikely to use condoms. This indicates that even among women who perceive their potential risk for HIV infection, power differentials in heterosexual relationships may make it difficult for them to protect themselves • Additional qualitative as well as quantitative research directed to understanding the influence of culture on women's sexual risk behavior is urgently needed to advance the development of culturally appropriate and effective prevention programs for all women. • Women with risky main sexual partners may be particularly difficult to target. • Interventions targeting women will also need to address past and present sexual victimization as a barrier to self-protective behavior	• Size of bisexual sample was very small • Predictive factors of condom use were not assessed

Results From PHREDA Project
KABP surveys conducted in 1993 and 1994
(Cares Project of High Risk Women)

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Women recruited from high risk women who were recruited from outreach workers in the Bayview Hunter's Point (24%), Tenderloin (32%), Mission (19%) & Haight Ashbury (25%) • N = 294	• Mean age = 29 yrs • 70% Afr-Amer • 7% Asian / PI • 7.5% Latina/Hisp. • 1% Native Amer • 11.6% White • 54% were uninsured • 31% lived in transient situations (17% shelters, 9% hotel / motel, 2.4% streets, 2% halfway house) • 2% self reported as HIV positive	Birth Control last Time: • 46% used condoms • 35% used nothing • 9% used BC pills • 23.6% almost never or never use birth control STD • 3% had a history of gonorrhea, 5% of syphilis, 5% PID and 20% another STD Condom Use • Women were less likely to always use condoms with main partners than other (53.5% vs. 19%) # partners past 6 mos. • 49% reported two or more partners	• The response rate for drug use was low: however, of those who reported use: • 51% reported crack • 22% reported heroin use • 14% cocaine use			

Results From PHREDA Project
KABP surveys conducted in 1993
in four public housing projects

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• 591 women enrolled in PHREDA project between March and May of 1993 • Surveys were conducted in 4 housing projects	• Mean age = 26 yrs • 2% were transient	• 43% had two or more partners in the past 6 months • 28% had 3 or more partners • 16% reported trading sex for money, drugs, food or shelter	• The response rate for drug use was low: however, of those who reported use: • 43% reported crack • 7% reported cocaine • .3% reported heroin use			

POPULATIONS IN THE SEX INDUSTRY

Published Behavioral Studies:

1. Hey Girlfriend: An Evaluation of AIDS Prevention Among Women in the Sex Industry.
   Dorfman LE, Derish PA, Cohen JB
   Health Education Quarterly, 1992; 19(1): 25-40

POPULATIONS IN THE SEX INDUSTRY

Behavioral Summary

The illicit nature of sex work makes it difficult to estimate the number of populations who engage in this behavior. In San Francisco there are probably more female sex workers than men, but there are also a significant number of males and transgenders who sell sex. For example, in a 1994 study of male IDUs, 77% of gay men, 56% of bisexual men and 18% of heterosexual men reported engaging in prostitution (the authors note that the relatively high levels of prostitution reported by homosexual and bisexual men may not be representative of other IDU communities).

In a 1990 street recruited cohort of female sex workers (the sample was predominantly African American), 8% were infected with HIV and 17% were infected with syphilis. Drug use was common in this cohort with over two thirds having smoked crack and over one third having injected drugs. Almost all (94%) of this cohort always or sometimes used condoms with clients, but only 25% did so with their main partners (this pattern remained for HIV and syphilis infected women). Most women felt that changing behavior with personal partners is more difficult than changing behavior with commercial partners. The women in this cohort also displayed the intention to reduce AIDS risk most often with clients rather than steady partners.

In addition to those who consider sex work their primary source of income, there are other populations who trade sex for drugs or money on occasion. Several studies have shown that populations who smoke crack cocaine often engage in trading sex for money or drugs. This behavior has been linked to high rates of STDs (especially in the African American community).

A recent KABB study of women living in four public housing projects in San Francisco found that 16% reported trading sex for money, drugs, food or shelter (PHREDA project, 1993). In a cross sectional survey of 458 young male youth attending a juvenile detention center, 14% reported having exchanged sex for drugs. Although there is no published research, it is believed that there are many homeless and runaway youth who engage in survival sex (especially in the Polk Street area).

According to several reports, there are also many women working in massage parlors who are refugees from Southeast Asian countries like Vietnam, Laos, and Cambodia as well as recent immigrants from the Philippines, Thailand,

and China. This population has not been formally studied, however, according to a recent report by the Multicultural Liaison Board, substance and injection drug use as well as high risk sexual behaviors are common in this population.

Recommendations for Prevention

Although most women in a cohort study of sex workers had changed their sexual behaviors with clients, they continued to engage in high risk behaviors with their main partners. Prevention should target behavior change with main partners as well as with clients (especially if their partners are injection drug or crack users). With street culture specific recruitment strategies, sex workers will participate in prevention programs and receive HIV counseling and testing. However, outreach and prevention cannot interrupt sex work as it is the only source of income for many populations.

Economics, addiction, and legalities are often barriers to prevention that need to be addressed within prevention programs. Because prostitution is illegal, using field staff who are indigenous to street life, prostitution and specific sex worker populations (i.e., transgenders) is an effective way of reaching these high risk populations. Outreach workers who are former IDUs or sex workers may also act as positive role models in their community. Specific outreach and prevention programs should be developed for transgender populations who sell sex and women who work in massage parlors.

Recommendations for Future Research

Because 72% of the sex workers in one study believe they are at risk for HIV infection, future research should concentrate on identifying barriers to adopting safer behavior for those who already understand their risk. Future research should look at populations of sex workers who are less visible such as transgenders, immigrants or refugees who work in massage parlors and street youth who engage in survival sex.

Hey Girlfriend: An Evaluation of AIDS Prevention Among Women in the Sex Industry
Dorfman LE, Derish PA, Cohen JB. Health Education Quarterly, 1992; 19(1):25-40.

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Between July 1, 1989 and June 30, 1990, 182 women who were sex workers were interviewed. • Surveys were filled out by all women, and open ended interviews were conducted with 58 participants. • Ethnographic notes were also evaluated by interviewers.	• 74% Afr-Amer • 6% Latina • 4% Native Amer • 17% White • Over-representation of African American women reflects outreach & recruitment efforts aimed at African American neighborhoods known for high drug, crack use & prostitution • Mean age = 30 yrs • 8% were infected with HIV at entry • 17% were infected with syphilis at entry	• 94% always or sometimes used condoms w/ clients but only 25% did so with their partners (this pattern remained for HIV & syphilis infected women) • 72% said they feel they are at risk for getting AIDS • Most women felt that changing behavior with personal partners is more difficult than changing behavior w/ commercial partners • Women displayed the intention to reduce AIDS risk most often with clients rather than steady partners	• 66% used crack • Syphilis was most prevalent among women who used crack exclusively (23% infected) • 39% of cohort had injected drugs • 11 of the 14 women who were HIV positive had injected drugs		• Further research efforts should concentrate on identifying barriers to adopting safer behavior for those who already understand their risk • Although most women had changed their behaviors with their clients, continued high risk behaviors with main partners may put these women at risk for HIV • Using field staff who are indigenous to street life and prostitution is an effective way of reaching prostitutes. • With appropriate (specific to the street culture) recruitment strategies prostitutes will participate in prevention programs • Outreach workers who are former IDUs or prostitutes can be effective and may act as positive role models	• Small sample size • Non-random sample (cannot generalize results to all prostitute populations due to high recruitment of African-American women • Project could only accommodate a limited number of women each day, so many women were turned away

ADULTS IN THE CRIMINAL JUSTICE SYSTEM

Published Behavioral Studies:

1. Patterns of Sexuality in a High-Risk Sample: Results from a Survey of New Intakes at a County Jail.
   Temple MT. Archives of Sexual Behavior, 1993; 22(2):111-129.

2. HIV Antibody Seroprevalence Among Prisoners Entering the California
   Correctional System
   Singleton J, Perkins C, Trachtenberg A, Hughes M, Kizer K, Ascher M
   The Western Journal of Medicine, October 1990;153 (4): 394-399

ADULTS IN THE CRIMINAL JUSTICE SYSTEM

Behavioral Summary

The state of California has the greatest number of inmates incarcerated in the United States with over 100,000 presently in custody. As of July 31, 1994 there were 246 female and 2,208 male paroles in San Francisco (California Department of Corrections). There is not a state prison in San Francisco, however, there are four San Francisco County Jails. According to the San Francisco Sheriff's Department (June, 1994), the average daily census of the San Francisco jails is 2,400, up 11.4% from the previous year. Ninety percent of the inmates are male, and 10% female. The recidivism rate is predicted to be 55%. The population is mainly comprised of ethnic and racial minorities: 50.2% African American, 27.4% Hispanic, 19.4% European American, 1.6% Asian and 1.2% Native American and Samoan.

On March 4, 1993, the San Francisco Sheriff's Department examined all the booking cards for the day, and ascertained that 29% of the incoming inmates had charges related to the sale of illegal narcotics. According to the San Francisco Sheriff's Department spokesman, approximately 70% of those in custody have substance abuse problems, and many are injection drug users.

Although no published behavioral studies that have been conducted with incarcerated adults in San Francisco, a recent cross sectional behavioral survey was done in the neighboring Contra Costa County Jail. This study sampled newly-arrested inmates who had been held in custody for three days or longer. Most of this sample self-identified as heterosexual and 73% were in a primary relationship. Over half of the sampled population had two or more partners in the past month and condom use was lower when having sex with a primary partner. Alcohol and drug use was high in this sample, with 22% drinking alcohol daily, 53% using marijuana, 30% using crack or cocaine, 31% using crank, and 11% using heroin in the past year. When comparing the behaviors of this sample to a population based sample surveyed with the same instrument, the incarcerated population was found to initiate sex at an earlier age, have intercourse more often, and were more likely to be classified as "high risk".

Several unpublished studies of the San Francisco jail population which document a profile of inmate medical and social service needs have been conducted. A review of the current literature suggests that the jail population, because of individual behaviors, and demographic characteristics are at high risk for HIV, STD's and TB. In addition, in 1992 a voluntary HIV

testing program began. To date, 1,200 inmates have been tested. The seropositivity rate is 8% for men and 16% for women.

At the State level, HIV testing in the Correctional System has been done only on consenting inmates when clinically indicated or upon inmate request. Because prisoners who test positive are housed separately and often the lose access to work programs, many do not choose to be tested.

In 1988, the California Department of Corrections, conducted a cross-sectional, blinded study to estimate HIV seroprevalence among incoming prisoners in California. This study found an overall seroprevalence of 2.5% among the 5,372 men tested and 3.1% among the 807 women tested. Seroprevalence was more than twice as high among men arrested in the San Francisco Bay Area (5.3%) as in those arrested in Southern California (1.9%) or Central California (1.2%). This study did not collect information on risk behaviors, however, the authors speculate that the higher seroprevalence rate among men arrested in San Francisco is due to the increased seroprevalence among IDUs in San Francisco.

Recommendations for Prevention

Providing HIV prevention to inmates in correctional institutions, as well as those in ancillary criminal justice systems, is a very effective and vital strategy. Incarceration provides the opportunity to reach some of the people that are the hardest to reach (IDUs, other substance users, and socioeconomically disadvantaged). Many of these populations may not avail themselves of community programs.

Education and prevention efforts should continue to be tailored to inmate populations. Such programs must be culturally appropriate since non-white populations are over represented in the criminal justice system. Prevention should be done on entry into a correctional facility, repeatedly during incarceration, upon release, as well as in the communities in which the prisoners will live when released. Condoms and bleach must be readily available to populations while they are incarcerated.

Recommendations for Future Research

The aforementioned studies sampled inmates as they were entering the correctional facility. This type of sampling shows that new inmates are at risk due to their behaviors before they were arrested. Future research should also investigate sexual behaviors after inmates have been in jail or prison. Even though injection drug use and sexual activity are prohibited among inmates,

these activities are well known to occur in the correctional system. Follow-up studies of a cohort of entering and current inmates would provide the most definitive information regarding HIV behaviors and transmission of HIV within correctional systems. Needs assessment and evaluation research for specific programs targeting populations in correctional facilities are needed.

Patterns of Sexuality in a High-Risk Sample: Results from a Survey of New Intakes at a County Jail. Temple MT. Archives of Sexual Behavior, 1993; 22(2):111-129.

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross Sectional Survey (comparable to survey of general population) • 72 hr or longer intakes were included and violent cases were oversampled due to a higher prevalence of nonviolence offenses w/ time period used. • 70% of intakes chosen were interviewed • The demographic characteristics resemble respondents in other justice system samples	• 31% Afr-Amer • 10% Latino/Hisp. • 58% White • 1% Other • 83% male • Median age = 27 yrs • Mean years of education = 12.5	• 96% self-identified as heterosexual • Mean age of sexual debut = 14.5 yrs • 73% were in a primary relationship • 57% had two or more partners in past year • No difference found in frequency of sex between men and women s p • Only 13% reported having anal sex more than once or twice a year • Respondents in primary relationships were less likely to use condoms during sex • The distribution of sexual risk-taking did not differ significantly by gender or race.	• 22% drink alcohol daily • 29% have at least 5 drinks at a time at least once a week • Drug use in past year: (30%) Crack/Coke (31%) Crank/Meth (53%) Marijuana (11%) Sedatives (11%) Heroin/Meth (17%) Other		• Comparing the jailed sample to a the general population sample which was surveyed with the same instrument, arrestees initiate sex at an earlier age, have intercourse more often, and are more likely to be categorized as high risk. Women in the arrestee sample had sexual behaviors similar to men. • Overall, these data indicate that criminal justice personnel should be trained and existing AIDS-related prevention programs in jails and prisons may need to be improved. • Because the sample was made up of new intakes, the results argue that prevention needs to address behaviors that take place before and after a jail sentence.	• Certain types of cases wee purposely not sampled in this study (i.e., public drunkenness) • Interviews being conducted while people were being booked may have influenced results. • The population based comparison sample had significantly less men

HOMELESS ADULTS

Published Behavioral Studies:

1. HIV and Tuberculosis Infection in San Francisco's Homeless Adults: Prevalence and Risk Factors in a Representative Sample. Zolopa AR, Hahn JA, Gorter R, Miranda J, Wlodarczyk D, Moss AR. JAMA, August 1994, 272 (6): 455-461

HOMELESS ADULTS

Behavioral Summary

The 1994 Comprehensive Housing Affordability Strategy Report estimates that the current homeless population in San Francisco is between 11,000 and 16,000 people. Although single men under 40 are disproportionately represented in the homeless population, about a third are families with children and 11% are single women. The United Conference of Mayors estimates that over half of the homeless population nationwide is African American.

To date, the most representative, cross-sectional study of HIV infection and behaviors among homeless adults in any major US city was conducted in San Francisco. This study sampled 1,226 homeless adults from shelters and lunch lines between 1990 and 1992. The seroprevalence of this population was 8.5%. Of these, 90% were asymptomatic and 75% did not know their HIV status.

For men, the behavioral factors that were independently predictive of HIV infection were homosexual and bisexual activity, selling sex, injecting drugs and injecting in a shooting gallery. Younger men were also at increased risk compared to older men. Among heterosexual African American men who never injected drugs, 4% were infected with HIV.
Among women, injection drug use was the best predictor of HIV infection.

Recommendations for Prevention

The San Francisco Department of Public Health estimates that 50% of the homeless in the City are substance abusers. Given the relationship between injection and other drug use and HIV infection that is emerging from initial research, any HIV prevention with this population must also address substance abuse issues. Needle exchange and other community level substance abuse prevention programs need to be tailored to meet the needs of homeless adults.

To be effective, HIV prevention should be integrated into all social services for homeless adults. However, not all homeless individuals utilize shelters, lunch lines or free clinics. According to a 1992 study in San Francisco, mentally disabled individuals are often unable or unwilling to access emergency shelters. Creative street outreach may be necessary to reach such sub-populations of homeless adults.

Recommendations for Future Research

Future research should enlarge the sampling frame of homeless adults to include SROs and other non-traditional sites. Over sampling women and mentally disabled individuals may be necessary to get a better understanding of their behavioral risk. More detailed sexual and drug using behavioral data will help in the development and evaluation of appropriate HIV prevention interventions.

HIV and Tuberculosis Infection in San Francisco's Homeless Adults: Prevalence and Risk Factors in a Representative Sample.
Zolopa AR, Hahn JA, Gorter R, Miranda J, Wlodarczyk D, Moss AR.
JAMA, August 1994; 272(6): 455-461

Study design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross sectional study of homeless adults in inner-city shelters and free meal programs • August 1990 - June 1992 • 1,226 homeless sampled from shelters and free food lines • All major facilities that provide meal and shelter services in SF provided in the study (comprising 73% of the shelter beds and 88% of the free lunch lines in SF) • Quota sampling was used in shelters • Systematic random sampling was used in lunch lines (excluding shelter dwellers) • 70% overall response	• 82% male • 49% Afr-Amer • 1% Asian / PI • 7% Latino / Hisp • 37% White • Median age = 36 yrs • Heterosexual: 78% (Men) 80% (Women) • Bisexual: 12% (Men) 8% (Women) • Gay / Lesbian: 10% (Men) 12% (Women) • 8.5% HIV seroprevalence • 60% of men and 40% of women had spent some time in jail or prison	** See predictors of HIV infection**	• Lifetime prevalence of injection drug use increased from 36% in those homeless less than 1 month to 49% in those homeless more than a year • Among the 14% of the homeless who are current injection drug users, nearly one in five were infected (double the prevalence in drug users in treatment)	Predictors of HIV • For women, injection drug use was the best predictor of HIV infection. • For men, multivariate analyses found the being gay, bisexual, African American, selling sex, injecting drugs, and injecting in a shooting gallery were all independent and significant risk factors for HIV infection. Younger men were also at increased risk compared to older men • Among Heterosexual African Americans who never injected drugs, 4% were infected w/ HIV (associated w/ multiple partners & exchanging $/drugs for sex)	• Given the risk factors present, the prevalence of HIV infection and lack of access to medical services, HIV in the homeless population represents a large public health problem • Homeless adults are at high risk for HIV infection through sexual practices and injection drug use and needle sharing behaviors	• Homeless populations who are mentally ill may not be represented in this sample. •

AFRICAN AMERICAN / BLACK

Published Behavioral Studies:

1. Condom Use in Multi-Ethnic Neighborhoods of San Francisco: The Population-Based AMEN (AIDS in Multi-Ethnic Neighborhoods) Study.
   Joseph A. Catania, PhD, Thomas J. Coates, PhD, Susan Kegeles, PhD, Mindy Thompson Fullilove, MD, John Peterson, PhD, Barbara Marin, PhD, David Siegel, MD, MPH, and Stephen Hulley, MD, MPH
   American Journal of Public Health, 1992; 82(2):

2. Risk for AIDS in multiethnic neighborhoods in San Francisco, California. The population-based AMEN Study.
   Fullilove MT; Wiley J; Fullilove RE 3d; Golden E; Catania J; Peterson J; Garrett K; Siegel D; Marin B; Kegeles S; et al.
   Western Journal of Medicine, 1992 July; 157(1):32-40.

3. Correlates of HIV risk behaviors in black and white San Francisco heterosexuals: the population-based AIDS in multiethnic neighborhoods (AMEN) study.
   Peterson JL; Grinstead OA; Golden E; Catania JA; Kegeles S; Coates TJ.
   Ethnicity and Disease, 1992 Fall, 2 (4) : 361-70.

4. High-Risk Sexual Behavior and Condom Use among Gay and Bisexual African-American Men.
   John L. Peterson, PhD, Thomas J. Coates, PhD, Joseph A. Catania, PhD, Lee Middleton, BA, Bobby Hilliard, MA, and Norma Hearst, MD, MPH
   American Journal of Public Health, November 1992; 82(11):1490-1494

KABB Behavioral Summaries:

5. A Report on the First Tracking Survey of AIDS Knowledge, Attitudes, and Behaviors in San Francisco's Black Communities, 1988-1989.
   Volume I
   Polaris Research and Development
   Noel A. Day: Amanda Houston-Hamilton, DMH; Danett Taylor, MPH; Michael Jang; Graham Crowe

6. Frameworks for Change. Report of the Multicultural Liaison Board.
   California State Office of AIDS.
   Working Draft
   July 1994

AFRICAN AMERICAN / BLACK

Behavioral Summary

African Americans make up the largest community of color in the United States and their representation in the HIV/AIDS epidemic is disproportionate to their true numbers in the overall population in the country. In California, African Americans are also disproportionately represented in the epidemic. In spite of these disturbing statistics, there remains little in the way of prevention or funding for prevention programs that are specifically targeted to this community. As once source notes, "African Americans are replacing Euro-American gay men as the 'poster child' representing the 'typical' person with AIDS. This shift in stereotype, however, has not been accompanied by a shift in funding or educational approach..."

The impact of the epidemic on the African American community has been quite severe. Recent reports state that HIV has become the number one cause of death of African American men between the ages of 25 and 44 years. Overall in California, the rate of African Americans living with AIDS is disproportionate to Euro-Americans. (The rate among African American women is 62 of every 100,000 and among Euro-American women is 8 of every 100,000. For men, the rate for African Americans is 386 of every 100,000 while for Euro-Americans, the rate is 184 of every 100,000) The combined effects of gender, race, socioeconomic status, drug use, and sexual orientation have combined to cause a health crisis of immeasurable scope within the African American Community. .

There have not been many behavioral studies in the African American community in San Francisco from which reliable behavioral data can be analyzed. Problems in sampling and collecting sensitive and sometimes embarrassing information on sexual behaviors is difficult. One study suggests that some participants may have under-reported behaviors they perceive to be embarrassing. However, the few studies and KABB's that have been done do suggest alarming trends in high-risk sexual and drug-using behaviors within this population.

A consistent finding across studies in this report is the high degree of unprotected intercourse, whether vaginal or anal, among both heterosexual and homosexual African Americans. The reasons for this behavior sometimes differ quite dramatically across gender lines and between heterosexual adults and self-identified gay and bisexual men, but there are also similarities which may be culturally determined.

Drug use during sex correlated highly with both unprotected vaginal and anal sex in one study. Another study found that there exists between heterosexual African American men and women a degree of gender politics that has a direct impact on negotiating condom use. This study found that "...traditional sexual roles, which permit men to have sexual freedom but censure women for the same activities, are still operating in the black community. A major problem in relationships between men and women is the lack of effective communication about sexual practices, particularly the use of condoms when partners are not mutually monogamous."

A study of African American gay men found that rates of unprotected anal intercourse in 1992 far surpassed those among gay and bisexual white men studied in 1988. (22% with primary partners and 35% with secondary partners among African American gay men, compared to 15% and 20% respectively among white gay men.)

Recommendations for Prevention

Many of the findings of these studies have serious implications for prevention programs. For those most at risk, efforts need to move beyond the provision of general information about AIDS transmission to a focus on personalized risk assessment, emphasis on the de-coupling of sex and drugs, increased clarity about the effectiveness of various risk reduction strategies, skill building in risk reduction, and the development of new community norms around issues such as condom use and needle cleaning. Interventions that focus on condom enjoyment, social skills training, and commitment issues may not be sufficient to increase condom use without also taking into account gender differences in the meanings that condoms and sexual assertiveness have for sexual partners.

Risk reduction campaigns for African American men should increase skills to eroticize condoms and to enhance their use, increase perceptions that condoms can prevent disease, and modify norms about condoms use. Also, because of the sensitivity around disclosure of homosexuality, many African American men who have sex with men do not self-identify as gay. In light of this, separate interventions for bisexually identified African American should be explored and tested.

HIV prevention programs that are tailored to young African American women should emphasize skills that women are able to use effectively to communicate with their partners about their unwillingness to engage in unsafe sexual behaviors. For these programs to be successful and to have maximum impact, peer educators should be used to deliver the

interventions. By serving as positive role models, they may be effective in countering the social pressures and environments that may support high-risk behaviors.

A high priority should be placed on linking HIV education with other services to the African American community. The Multicultural Liaison Board suggests these linkages should be in the following areas: health care services, substance abuse services, homeless and food services, childcare services, and mental health services. The Board feels that this linkage is particularly important for women and youth.

Recommendations for Future Research

As is evidenced in this report, behavioral studies targeting various groups within the African American community who are at high-risk for HIV infection are seriously needed. In addition, population based studies within this community are needed if there is to be a greater understanding of the effects of class, gender, drug use, sexual orientation, and cultural norms and values on behaviors known to transmit the virus.

While it has been strongly indicated by the findings of several studies that these factors all contribute to some degree to the transmission of the virus within this community, there is no reliable evidence of the differential effects of each factor, nor how various cultural norms impact on the delivery of prevention messages and the rate of behavioral change within the community.

In the area of sexual negotiation and condom use among heterosexual African American adults, research should focus on understanding the role of the power dynamics between African American men and women in negotiating condom use, determining the nature of sexual negotiation among African American women and men, determining the predictors of successful sexual negotiation among these populations, and identifying the factors driving the temporal relationship between sexual negotiation and condom use.

Condom Use in Multi-Ethnic Neighborhoods of San Francisco: The Population-Based AMEN (AIDS in Multi-Ethnic Neighborhoods) Study.
Joseph A. Catania, PhD, Thomas J. Coates, PhD, Susan Kegeles, PhD, Mindy Thompson Fullilove, MD, John Peterson, PhD, Barbara Marin, PhD, David Siegel, MD, MPH, and Stephen Hulley, MD, MPH
American Journal of Public Health , February 1992; 82(2):

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• Household probability sample of unmarried men and women 20 to 44 years in 16 census tracts characterized by high rates of STDs and admission to drug programs; similar proportions of Black, White, and Hispanic residents; and proximity to areas of high HIV seroprevalence. • 4234 households were contacted, 2755 met survey criteria, and 1770 volunteered.	• Specific Breakdown (%) (n = 1770): Men: 49.7 Women: 50.3 White: 41 African American: 26 Latino: 25 Other racial/ethnic groups: 8 • Median Income: $18,000 • 33% less than high school education • Only sexually active included (n = 1229) (%): White: 42 African American: 32 Latino: 26 Heterosexuals (%): Men: 44 Women: 47	• Unmarried heterosexuals were poor condom users. • Those w/multiple sexual partners were least likely to be using condoms. • Black and Hispanic women were less likely than White women to have sexual partners who always use condoms.	• Findings are limited in that the results are based on cross-sectional design - authors unable to estimate condom use levels for non respondents or differentiate condom use for birth control from that for disease prevention.	• Sexual communication skills are a key influence on condom use across social strata. • Perceived effects of condoms on sexual pleasure was a consistent influence on condom use across social strata.		• Results based on a cross-sectional design, and unable to estimate condom use levels for non respondents or differentiate condom use for birth control from that for disease prevention.

Risk for AIDS in multiethnic neighborhoods in San Francisco, California. The population-based AMEN Study. Fullilove MT; Wiley J; Fullilove RE 3d; Golden E; Catania J; Peterson J; Garrett K; Siegel D; Marin B; Kegeles S; et al. Western Journal of Medicine, 1992 Jul, 157(1):32-40.

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• Target population defined as: currently unmarried men and women, aged 20-44 at initial contact, living in 16 census tracts of San Francisco. • Tracts characterized by: -high rates of reportable sexually-transmitted diseases among women -high rates of admission to drug detox programs -roughly equal numbers of black, white and Hispanic residents. • 4234 households were contacted, 2755 met survey criteria, and 1770 volunteered.	• Gender: Men (%): 77.0 Women (%): 78.0 • Age: Men: White: 397 Black: 167 Hispanic: 240 Other: 76 Women: White: 339 Black: 289 Hispanic: 195 Other: 67 • Income: $0-5,999: 414 $6-17,999: 664 $18-29,999: 442 $30-49,999: 194 $50,000 +: 45 • Education: Less than HS: 246 HS Grad: 374 Some College: 650 College Degree: 307 Postgraduate: 181	• Homosexually active men and injection drug users reported higher rates of all the other risk behaviors than the rest of the population. One or more risk behaviors in the past year: • lowest among Hispanic women (5%) • highest among white women ((21%) • The study shows that HIV infection in SF has occurred predominantly among homosexually-active men, secondarily among injection drug users, and hardly at all in the rest of the population. • Prevalence of risk behaviors across race/gender subgroups of people who are neither homosexually-active men nor injection drug users ranges from 5% to 21%.		• Having a sex partner who used injection drugs. • Having unprotected sex w/ more than four partners in the past year. • Among women, having a homosexually active male partner.	• Prevention efforts need to be redoubled among individuals who engage in risk behaviors and who fail to perceive (or who deny) the degree to which they are at risk.	• These behavioral data underestimate true levels of risk behavior. -some may under-report behaviors they perceive to be embarrassing. -some may not be aware of their risk status.

Correlates of HIV risk behaviors in black and white San Francisco heterosexuals: the population-based AIDS in multiethnic neighborhoods (AMEN) study.
Peterson JL, Grinstead OA, Golden E, Catania JA, Kegeles S, Coates TJ
Ethnicity and Disease, 1992 Fall, 2 (4): 361-70.

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• Target population defined as: currently unmarried men and women, aged 20-44 at initial contact, living in 16 census tracts of San Francisco. • Tracts characterized by: -high rates of reportable sexually-transmitted diseases among women -high rates of admission to drug detox programs -roughly equal numbers of black, white and Hispanic residents. • 4234 households were contacted, 2755 met survey criteria, and 1770 volunteered.	• Gender: Men: n = 320 Women: n = 396 • Mean Age (years): Men: 30.4 Women: 30.5 • Race (%): MEN: White: (49) Black: (80) Hispanic: (82) WOMEN: White: (42) Black: (39) Hispanic: (19) • Income (%): MEN: < 12,000: (35) 12-39,999: (55) 40+: (10) WOMEN: < 12,000: (43) 12-39,999: (51) 40+: (6)			Consistent condom use is related to: • Labeling one's past sexual behavior as "risky" for HIV transmission • Perceiving condoms as enhancing or at least not interfering with one's sexual enjoyment • Having a strong commitment to use condoms • Having good sexual communication skills	• Interventions that focus on condom enjoyment, social skills training, and commitment issues may not be sufficient to increase condom use w/out also taking into account gender differences in the meanings that condoms and sexual assertiveness have for sexual partners.	• Did not examine social norms, social support, and help-seeking contingencies, which have been hypothesized to influence problem labeling, condom commitment, and condom use.

High-Risk Sexual Behavior and Condom Use among Gay and Bisexual African-American Men
John L. Peterson, PhD, Thomas J. Coates, PhD, Joseph A. Catania, PhD, Lee Middleton, BA, Bobby Hilliard, MA, and Norma Hearst, MD, MPH
American Journal of Public Health, November 1992, Vol. 82, No. 11

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• African-American Men's Health Study Sample size: n = 250 • Face to face, anonymous interviews. • Recruitment over 11 months between 1989 and 1990 in San Francisco, Berkeley, and Oakland. • Inclusion criteria: • race (African American) • sex (male) • age (18 yrs. +) • sexual identification (gay or bisexual)	• Age range (%): < 20 (1) 20-29 (37) 30-39 (60) 39 + (2) • 57% earned $15,000 or less per year. • One-third w/ 12 yrs. education. Half w/ between 13 to 16 yrs. • 89% single • 37% engaged in prostitution • 25% used injection drugs	• In last six months: 22% unprotected anal w/ primary partners. 35% unprotected anal w/ secondary partners. •19% unprotected anal w/ejaculation w/ primary partners. 30% unprotected anal w/ejaculation w/ secondary partners. • Higher prevalence of unprotected anal intercourse in the past 6 months in 1990 than did gay and bisexual White men in 1988.		For unprotected anal intercourse: • Two or more marginal status indicators (e.g., being low income, having been paid for sex, and/or having used injection drugs) • Felt discomfort w/ coming out • Perceived themselves at greater risk • Felt they did not receive support for their concerns about unsafe sex. For condom use: • Strong beliefs that condom use was normative • Strong self-efficacy to practice safer sex • Positive expectations about using condoms.	• Risk reduction campaigns for AA men should increase skills to eroticize condoms and to enhance their use, increase perceptions that condoms can prevent disease, modify norms about condom use. • Separate interventions for AA bisexually identified men. • Financial incentives may have to be offered to recruit eligible participants for interventions as indicated by the difficulty in recruitment for this study.	• Payment of participants may have led to an over representation of men who needed money. • There is no established method to determine the validity of self-reports of sexual behavior.

Risk for AIDS in multiethnic neighborhoods in San Francisco, California. The population-based AMEN Study. Fullilove MT; Wiley J; Fullilove RE 3d; Golden E; Catania J; Peterson J; Garrett K; Siegel D; Marin B; Kegeles S; et al. Western Journal of Medicine, 1992 Jul, 157(1):32-40.

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• Target population defined as: currently unmarried men and women, aged 20-44 at initial contact, living in 16 census tracts of San Francisco. • Tracts characterized by: -high rates of reportable sexually-transmitted diseases among women -high rates of admission to drug detox programs -roughly equal numbers of black, white and Hispanic residents. • 4234 households were contacted, 2755 met survey criteria, and 1770 volunteered.	• Gender: Men (%): 77.0 Women (%): 78.0 • Age: Men: White: 397 Black: 167 Hispanic: 240 Other: 76 Women: White: 339 Black: 289 Hispanic: 195 Other: 67 • Income: $0-5,999: 414 $6-17,999: 664 $18-29,999: 442 $30-49,999: 194 $50,000 +: 45 • Education: Less than HS: 246 HS Grad: 374 Some College: 650 College Degree: 307 Postgraduate: 181	• Homosexually active men and injection drug users reported higher rates of all the other risk behaviors than the rest of the population. • One or more risk behaviors in the past year: • Lowest among Hispanic women (5%) • Highest among white women ((21%) • The study shows that HIV infection in SF has occurred predominantly among homosexually-active men, secondarily among injection drug users, and hardly at all in the rest of the population. • Prevalence of risk behaviors across race/gender subgroups of people who are neither homosexually-active men nor injection drug users ranges from 5% to 21%.		• Having a sex partner who used injection drugs. • Having unprotected sex w/ more than four partners in the past year. • Among women, having a homosexually active male partner.	• Prevention efforts need to be redoubled among individuals who engage in risk behaviors and who fail to perceive (or who deny) the degree to which they are at risk.	• These behavioral data underestimate true levels of risk behavior. -some may under-report behaviors they perceive to be embarrassing. -some may not be aware of their risk status.

A Report on the First Tracking Survey of AIDS Knowledge, Attitudes, and Behaviors in San Francisco's Black Communities, 1988-1989.
Volume I
Polaris Research and Development
Noel A. Day: Amanda Houston-Hamilton, DMH; Danett Taylor, MPH; Michael Jang; Graham Crowe

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• This survey was conducted in the fall and winter of 1988-89. Face-to-face interviews were conducted with 350 Black adult San Franciscans. • Respondents were selected using a random block-random household sampling procedure in those census tracts that had Black populations of 50% or more in 1980.		• Analysis showed that many of those reporting that they'd engaged in protected vaginal or anal intercourse also engaged in unprotected intercourse and did so with greater frequency.	• Respondents reported a high degree of substance abuse. Previous year: Marijuana: 44% Cocaine: 29% Crack: 17% IVDU: 7.4%	• Respondents who reported that they had a higher than average number of sexual partners during the year were younger, more likely to have risky partners or to participate in unprotected sexual intercourse, and more likely to be bisexual than either heterosexual or homosexual. • Drug use during sex correlated highly with having unprotected vaginal and anal sex and with having partners who were HIV+, had an STD, or were intravenous drug users.	• Prevention efforts need to be more carefully targeted on various "market segments." • The population that is not at risk has to be supported in maintaining safe behaviors and the general message that AIDS is having a disproportionate effect on Blacks has to continue to be emphasized. • For those most at risk, efforts need to move beyond the provision of general information about AIDS transmission to a focus on personalized risk assessment, emphasis on the de-coupling of sex and drugs, increased clarity about the effectiveness of various risk reduction strategies, skill building in risk reduction, and the development of new community norms around issues such as condom use and needle cleaning.	

ASIAN / PACIFIC ISLANDER

Published Behavioral Studies:

1. HIV knowledge, communication, and risk behaviors among white, Chinese-,and Filipino-American adolescents in a high-prevalence AIDS epicenter: a comparative analysis.
   Horan PF; DiClemente RJ.
   Ethnicity and Disease, 1993 Spring, 3(2):97-105.

2. Sexual Practices of Heterosexual Asian-American Young Adults: Implications for Risk of HIV Infection.
   Susan D. Cochran, PhD., Vickie M. Mays, PhD., and Laurie Leung, BA.
   Archives of Sexual Behavior, 1991; 2094):

KABB Behavioral Summaries:

3. AIDS Knowledge, Attitudes, Beliefs and Behaviors in Southeast Asian Communities in San Francisco.
   Volume 1: Findings, Summary and Conclusions, Executive Summary
   Center for Southeast Asian Refugee Resettlement
   Kenji Murase, D.S.W.; Susan Sung, D.S.W.; Vu Duc Vuong, M.S.W., J.D.
   March 1991

4. A Survey of AIDS Knowledge, Attitudes and Behaviors in San Francisco's American-Indian, Filipino and Latino Gay and Bisexual Male Communities.
   Prepared for the San Francisco Department of Public Health, AIDS Office by Fairbank, Bregman & Maulin, Inc. May 15, 1991.

5. Report on a Survey of AIDS Knowledge, Attitudes and Behaviors in San Francisco's Chinese Communities Executive Summary.
   Asian American Recovery Services, Inc.
   Davis Y. Ja, PhD; Kerrily J. Kitano, M.S.W.; Aaron Ebata, PhD.
   May 23, 1990

6. Report on a Survey of AIDS Knowledge, Attitudes and Behaviors in San Francisco's Japanese Communities Executive Summary.
   Asian American Recovery Services, Inc.
   Davis Y. Ja, PhD; Kerrily J. Kitano, M.S.W.; Aaron Ebata, PhD.
   May 23, 1990

7. AIDS Knowledge, Attitudes, Beliefs and Behaviors in a Household Survey of Filipinos in San Francisco.
Volume 1: Findings, Summary and Conclusions
The San Francisco Department of Public Health AIDS Surveillance Office, The Asian American Health Forum, Filipino Task Force on AIDS-Northern California
Lydia Gorrez, PhD; Maria Rosario G. Araneta, MPH, Jaime Geaga

ASIAN / PACIFIC ISLANDER

Behavioral Summary

Asian/Pacific Islanders are an ethnic group that appears to be at lower risk of HIV infection than African Americans, Latinos and Whites, according to current HIV epidemiological data. In spite of this somewhat misleading statistic, however, there is cause to be concerned about the future incidence of HIV infection in this community. A recent study indicates that between 1992 and 1993 Asian/Pacific Islander's in San Francisco were the only group that experienced an increase in the percentage of reported AIDS cases.

One of the barriers to understanding the distribution of the disease within this population is the enormity of the various cultural and linguistic groups that comprise what is known as the Asian/Pacific Islander community. According to one source, there are over 39 distinct cultural and linguistic groups within the overall community.

Although several published behavioral studies and KABB's have been conducted within the community, specifically among Southeast Asians, Filipinos, Chinese, and Japanese, there has never been a population based behavioral study conducted among Asian/Pacific Islander's in San Francisco.

Due to the rich cultural diversity of this community, it is difficult to generalize the limited behavioral findings to the population as a whole. However, there are several behavioral factors that seem to cross cultural boundaries that may be helpful in designing effective prevention strategies.

Across all groups studied, rates of unprotected intercourse are extremely high. For example, the majority of the Southeast Asian sample were found to engage in sex without a condom. 65% of the Chinese sample reported that they "never" or "sometimes" used condoms and 63% of the Japanese sample reported sexual intercourse without a condom in the last year. Particularly alarming is the finding that in spite of the fact that 77% of a sample of Asian-American young adults aged 18 to 25 have used condoms for sexual intercourse, 93% reported also practicing sexual intercourse without condoms. It is clear that the risks associated with unprotected intercourse have not been acted on by the majority of the study samples.

The impact of culture on various risk behaviors cannot be underestimated. For example, among the Southeast Asian sample, Laotians had the highest rate of unsafe drug use. It is believed that this fact may be attributable to a

greater tolerance of substance use in parts of their native country. Another study found significant differences in sexual activity and communication skills among Chinese and Filipino students, suggesting that prevention messages should be delivered separately to each group.

Recommendations for Prevention

In order for HIV/AIDS prevention programs to have the greatest impact on the Asian/Pacific Islander community, the vast cultural and linguistic diversity within the community must be acknowledged and reflected in all prevention programs and activities.

One study suggests that diversity reinforces the health promotion message to ethnic populations that risk of infection is associated with the behavior of the individual and not with group membership. The same study found that more initial intervention time may need to be devoted to overcoming cultural barriers against discussion of HIV and sexual behaviors when working with Chinese and Filipino students.

It was found among the Southeast Asian sample that overall level of knowledge about AIDS is critically deficient. It is obvious that AIDS education campaigns directed to the general public have had little impact upon Southeast Asian communities. This data points to a compelling need for a comprehensive AIDS education campaign specifically designed and targeted to Southeast Asian communities.
A similar campaign has been recommended for the Chinese community.

Recommendations for Future Research

In light of the many distinct cultural and linguistic groups that comprise the Asian/Pacific Islander community, the need for targeted behavioral research is extremely important. Preliminary findings of the impact and influence of various cultural beliefs and norms on risk behaviors suggests the need for further research on this association.

In a culture where such issues as drug use, pre-marital sex, and homosexuality are forbidden topics for public discourse, the need to understand how these issues can be addressed effectively and respectfully will be an important contribution to prevention efforts within this population.

HIV infection according to Asian/Pacific Islander ethnicity, mode of transmission, age, gender, and year of immigration to the US. are all areas in which additional information is necessary for prevention efforts to succeed.

HIV Knowledge Communication and Risk Behaviors Among White, Chinese-Filipino-American Adolescents in a High Prevalence AIDS Epicenter: A Comparative Analysis
Horan PF, DiClemente RJ.
Ethnicity & Disease, 1993: 3: 97-105

Study Design, sample size and method, entry criteria, year of sample	Sample Demographics	Sexual Behaviors	Drug Use Behaviors	Predictors	Implications for Prevention	Comments / Limitations
• Cross-sectional self administered survey, • 1989 • 1,272 high school students (10th and 11th grade) filled out survey in either family life or social studies classes • Only students who identified as Chinese, Filipino or White were in sample	• Females: (52% of Chinese; 59% of Filipino; and 58% of White) • Chinese were 46.9% of original sample • Filipinos were 16.3% of the original sample • Whites were 8.6%	• Only 13% of Chinese students were sexually active • 32% of Filipinos were sexually active • 37% of Whites were sexually active • Among sexually active students, no racial ethnic differences were found for the total sexual behavior risk index • Chinese students were less able to communicate with others about HIV disease and prevention • Chinese and Filipino students had less misconceptions, but Whites had higher knowledge prevention	• 2.1 % reported using injection drugs (2.2% of White students, 3.3% of Filipino students, and 1.4 of White students		• Chinese and Filipino students should not be grouped together since there were significant differences in sexual activity and communication skills • Filipino students have sexual activity rates similar to those of White students but share poorer HIV prevention knowledge and lesser ability talk about HIV • Diversity reinforces the health promotion message to ethnic populations that risk of infection is associated with the behavior of the individual and not with group membership • More initial intervention time may need to be devoted to overcoming cultural barriers against discussion of HIV and sexual behaviors when working with Chinese and Filipino students	• Cultural differences and difficulty in communicating about sex, may have contributed to lower rates of sexual activity among Chinese students • Sexual behaviors questions were not very specific

Sexual Practices of Heterosexual Asian-American Young Adults: Implications for Risk of HIV Infection.
Susan D. Cochran, PhD., Vickie M. Mays, PhD., and Laurie Leung, BA.
Archives of Sexual Behavior, 1991; 20(4):

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
Questionnaires were completed by 153 individuals attending one of several Southern California universities.	Half US born. Immigrant breakdown: Korea: n=23 Taiwan: n=16 Philippines: n=13 Vietnam: n=7 China: n=4 Hong Kong: n=4 Indonesia: n=2 Thailand: n=1 Other: n=5 Range in age from 18 to 25 years. All were unmarried and self-defined as heterosexual. 33% from middle-class backgrounds 53% from upper middle-class backgrounds.	77% have used condoms for sexual intercourse at some point. 93% also practiced sexual intercourse without condoms. 15% had tried anal intercourse at least once. 17% reported that they had been possibly exposed to a STD at some point.			Efforts designed to influence sexual behaviors in young heterosexual ethnic minorities where sex-role influences are present must take notice of these gender differences if the efforts are to be effective.	Due to the small numbers of individuals from each foreign country, all the subgroups were analyzed together.

AIDS Knowledge, Attitudes, Beliefs and Behaviors in Southeast Asian Communities in San Francisco. Volume 1: Findings, Summary and Conclusions, Executive Summary
Center for Southeast Asian Refugee Resettlement
Kenji Murase, D.S.W.; Susan Sung, D.S.W.; Vu Duc Vuong, M.S.W., J.D.
March 1991

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
Respondents were randomly selected among households in six Census tracts, covering 60 blocks, in the Tenderloin area. Response rate: Vietnamese: 69% Laotians: 78% Cambodians: 80% Interviewed in the Fall 1990.	Cambodian: n=87 Laotian: n=91 Vietnamese: n=205 Age range: 18 to 60	Rate of high risk sexual behavior: Cambodian: 5.7% Vietnamese: 8.8% Laotians: 20.9% One half of respondents in all 3 samples stated they had not changed their sexual behavior. Multiple sexual partners: Cambodians: 4% Vietnamese: 12% Laotians: 24% Laotians had the highest incidence of high-risk partners, followed by Vietnamese and Cambodians. The majority of all three samples were found to engage in sex without use of a condom. The high rate of non-condom use may reflect the high proportion of married respondents and single partner relationships in the samples.	Laotian sample had the highest unsafe drug use rate at 11%. May be attributable to a greater tolerance of substance use in parts of their native country, associated with the production of opium in the region bordering Burma. Alcohol consumption was low.		In relation to AIDS education, a major study finding is that the overall level of knowledge among Southeast Asians about AIDS is critically deficient. AIDS education campaigns directed to the general public have had little impact upon Southeast Asian communities. The data point to a compelling need for a comprehensive AIDS education campaign specifically designed and targeted to Southeast Asian communities. The high risk groups most in need of targeted intervention are Southeast Asian homosexual and bisexual males.	In limiting this study to Southeast Asians living in the Tenderloin area, the sample may be skewed towards the low income recent refugee population. More acculturated families in the middle and upper socio-economic classes would be under-represented in this study.

Report on a Survey of AIDS Knowledge, Attitudes and Behaviors in San Francisco's Chinese Communities Executive Summary.
Asian American Recovery Services, Inc.
Davis Y. Ja, PhD; Kerrily J. Kitano, M.S.W.; Aaron Ebata, PhD.
May 23, 1990

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
A total of 192 Chinese residents of San Francisco were interviewed between March 1989 - January 1990. Respondents were selected using a randomized block and household sampling procedure from 78 blocks randomly selected from census tracts with the highest density of Chinese residents.		5.2% reported having sexual relations with prostitutes. 65.4% indicated they "never" or "sometimes" used condoms. Only 11% reported "always" using condoms. 41.1% reported ever having vaginal sex without a condom. 15.6% reported oral sex with a woman. 8.9% reported oral sex with a male. Four male respondents each reported anal sexual intercourse with a condom and without a condom.	Drug use minimal. Only one person reported use of drugs intravenously.		Substantial cultural and linguistic barriers seem to exist for this community. Much of the results point to a need for a major and comprehensive campaign on almost all aspects of AIDS and HIV transmission to the Chinese community. Media messages must differentiate the real dangers of AIDS transmission from those that are fueled by fear and misinformation. Health education presentations must also be increased to captive groups of workers, organizations, youth parents, and providers.	

Report on a Survey of AIDS Knowledge, Attitudes and Behaviors in San Francisco's Japanese Communities Executive Summary.
Asian American Recovery Services, Inc.
Davis Y. Ja, PhD; Kerrily J. Kitano, M.S.W.; Aaron Ebata, PhD.
May 23, 1990

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
Survey conducted in San Francisco between the Spring and Winter of 1989. The survey consists of 200 face to face interviews with a population-based sample of Japanese adult residents of San Francisco. Of the 200 interviews, 58 were selected based on a random block and household sampling procedure in census tracts with the highest Japanese population. The remaining 142 interviews were selected from a private directory listing of Japanese residents in San Francisco.		Only one of every ten people said they always used condoms during sexual intercourse. During the past year, 63% of the respondents reported sexual intercourse without a condom. 7% reported anal intercourse without a condom. 12.5% reported having a female prostitute as a sexual partner and 1.5% reported male prostitutes as sexual partners.	Alcohol was found to be used at least 3-4 times weekly by 27% of the total population. Unsafe drug use with a needle was found in only one respondent.		A comprehensive campaign aimed specifically at the Japanese community utilizing both Japanese and English is recommended. Specific aims of the campaign would be to reduce misinformation, addressing the incidence of unprotected sexual activity, and of the dangers of unsafe alcohol and drug activity and its potential relationship to unsafe sexual activity.	In risk behavior, a small proportion of the people interviewed displayed unsafe behavior. However, given the cultural barriers, it isn't clear whether the interviewees were responding with total accuracy to these questions.

AIDS Knowledge, Attitudes, Beliefs and Behaviors in a Household Survey of Filipinos in San Francisco. Volume 1: Findings, Summary and Conclusions
The San Francisco Department of Public Health AIDS Surveillance Office, The Asian American Health Forum, Filipino Task Force on AIDS-Northern California
Lydia Gorrez, PhD; Maria Rosario G. Araneta, MPH, Jaime Geaga

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
October 1989 through January 1990. 400 randomly selected self-identified Filipinos were interviewed in person by trained interviewers using standardized questionnaires translated into three Filipino languages. Sampling was limited to 15 census tracts with high densities of Filipino residents (defined as census tracts where at least 8% of the residents are Filipinos, according to the 1980 Census).		6% reported having unprotected sex with homosexuals, bisexuals, HIV-1 infected persons, female prostitutes, transfusion recipients (prior to 1985), multiple sex partners and persons with venereal diseases and unknown sex histories.	None of the 400 respondents reported intravenous drug abuse nor having an IVDU sex partner.	Persons with risk factors were significantly more likely to have multiple sex partners and to use drugs, including cocaine, crack, marijuana, PCP, speed and Quaaludes and were more likely to use drugs or alcohol during sex.	The belief that HIV-1 can be transmitted through casual modes this late into the San Francisco AIDS epidemic, suggests a need for AIDS education specific and comprehensible to the Filipino community.	The fiscal and logistic constraints in limiting sampling to high density Filipino areas resulted in an underestimation of US born Filipinos, whose sexual and drug practices may differ from those sampled.

LATINO / HISPANIC

Published Behavioral Studies:

1. Condom use among Hispanic men with secondary female sexual partners.
Marin BV; Gomez CA; Tschann JM.
Public Health Reports, 1993 Nov-Dec, 108(6):742-50.

2. Multiple heterosexual partners and condom use among Hispanics and non-Hispanic whites.
Van Oss Marin B; Gomez CA; Hearst N.
Family Planning Perspectives, 1993 Jul-Aug, 25(4):170-4.

3. Acculturation and gender differences in sexual attitudes and behaviors: Hispanic vs. non-Hispanic white unmarried adults.
Marin BV; Tschann JM; Gomez CA; Kegeles SM.
American Journal of Public Health, 1993 Dec, 83(12):1759-61.

4. Correlates of HIV risk behaviors in black and white San Francisco heterosexuals: the population-based AIDS in multiethnic neighborhoods (AMEN) study.
Peterson JL, Grinstead OA, Golden E, Catania JA, Kegeles S, Coates TJ
Ethnicity and Disease, 1992 Fall, 2 (4): 361-70.

5. Risk for AIDS in multiethnic neighborhoods in San Francisco, California. The population-based AMEN Study.
Fullilove MT; Wiley J; Fullilove RE 3d; Golden E; Catania J; Peterson J; Garrett K; Siegel D; Marin B; Kegeles S; et al.
Western Journal of Medicine, Jul 1992, 157(1):32-40.

6. Condom Use in Multi-Ethnic Neighborhoods of San Francisco: The Population-Based AMEN (AIDS in Multi-Ethnic Neighborhoods) Study.
Joseph A. Catania, PhD, Thomas J. Coates, PhD, Susan Kegeles, PhD, Mindy Thompson Fullilove, MD, John Peterson, PhD, Barbara Marin, PhD, David Siegel, MD, MPH, and Stephen Hulley, MD, MPH
American Journal of Public Health, February 1992; 82(2):

7. Effects of Acculturation on Knowledge of AIDS and HIV Among Hispanics
Barbara V. Marin and Gerardo Marin
Hispanic Journal of Behavioral Sciences, May 1990; 12(2): 110-112.

8. AIDS Prevention Among Hispanics: Needs, Risk Behaviors, and Cultural Values.
Gerardo Marin, PhD
Public Health Reports, September-October 1989; 104(5).

KABB Behavioral Summaries:

9. Report on a Tracking Survey of AIDS Knowledge, Attitudes and Behaviors in San Francisco's Latino Communities.
Fairbank, Bregman & Maullin, Inc.
March 10, 1989

LATINO / HISPANIC

Behavioral Summary

Multiple sources of data indicate that Hispanics are over-represented in reported AIDS cases, at least twice that of their proportion of the population. It has also been found that their rate of infection by HIV is three times higher than among non-Hispanic whites.

Several factors have been determined to be predictors of high-risk sexual behaviors among heterosexual Hispanic adults. Studies have found that high self-efficacy to use condoms is strongly associated with prior use of condoms and low self-efficacy is associated with discomfort with sexuality. For men and women who report multiple partners, predictors include being unmarried, level of acculturation (less acculturated men and more highly acculturated women were more likely to report multiple heterosexual partners), and the interaction of ethnicity, language, and gender.

The most significant factor affecting sexual risk taking has to do with issues of culture. Among Hispanics, acculturation is a significant predictor of many health-related behaviors. For example, the cultural value of machismo promotes sexual intercourse with prostitutes to demonstrate virility and as a way of achieving sexual satisfaction. Additionally, Hispanic men who have sex with men may not consider themselves homosexual, making it difficult to target this group with messages that focus on identity rather than behavior. One study on acculturation and gender differences in sexual attitudes and behaviors found that condom use was low in all groups being studied, but Hispanic women reported lower condom use than white women. This study also found that Hispanics, generally, had poorer attitudes toward condoms and were less likely to believe they can avoid AIDS than non-Hispanic whites.

An important finding that is culturally specific to Hispanics is that 13% of San Francisco Hispanics report receiving injections of medications or vitamins outside of medical settings and perceive less of a risk of transmission with these injections than with injecting illegal drugs. This has serious implications for HIV prevention.

Recommendations for Prevention

Problems in promoting the use of condoms by Hispanics are their association with prostitution and uncleanliness and perceived diminished sensation,

discomfort, or inconvenience. Prevention campaigns need to address these barriers to be effective.

Prevention interventions also need to consider using culture-specific values and norms, disseminating information in terms that are appropriate for Hispanics, and using channels of information that are accessed by them. Specifically, campaigns that seek to educate the Hispanic community about HIV should target messages to less acculturated Hispanics (those most likely to speak Spanish, use Spanish-language media, and have Hispanic friends) and should emphasize the ways in which HIV is not transmitted and the latent nature of the virus.

Recommendations for Future Research

From these findings it is apparent that a clear understanding of the culturally specific determinants of risk-behaviors is seriously lacking. Research needs to begin to focus on how culture, ethnicity, gender, and region interact to either facilitate or impede high-risk sexual and drug-using behaviors.

Research on the cultural meaning of such Hispanic values as simpatia, familialism, personalismo, and power distance is urgently needed. Appropriate wording and communication channels need to be identified in order to transmit messages that will be perceived as credible and that will reach the largest possible audience.

Condom Use Among Hispanic Men with Secondary Female Sexual Partners.
Marin BV; Gomez CA; Tschann JM.
Public Health Reports, 1993 Nov-Dec, 108(6):742-50.

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• Stratified clustered random digit dial telephone sampling strategy (modified Mitofsky-Waksberg) in nine States with concentrations of Hispanics ranging from 5% to 38% (NY, NJ, MA, CT, CA, AZ, CO, NM). • 361 of 968 Hispanic men ages 18-49 years who reported having more than one female partner in 12 months prior to sampling. • Response Rate: 58%	• Age (%) 18-25 (47.8) 26-32 (23.9) 33-40 (17.5 41-49 (10.8) • Marital Status (%) Married (31.0) Not Married (69.0) • Acculturation (%) Low (34.6) Medium (35.7) High (29.6) • Origin (%) Mexican (37.4) Puerto Rican (23.5) Dominican (15.8) Other (23.3)	Behavioral Factors: • Carrying condoms: in this sample, carrying condoms an indicator of preparedness for safe sex w/ a secondary partner and of greater experience w/condoms. • Self-efficacy to use condoms strongly associated with prior use of condoms.	• No relationship was found between frequency of condoms use and use of drugs or alcohol before sex. • Perception that one could use condoms after drinking or using drugs included.	Predictors of condom use with secondary partners. • Carrying condoms. • Self-efficacy to use condoms. • Positive attitude toward condom use. • Having friends who used condoms. • Personally knowing someone with HIV/AIDS predicted more carrying and more use of condoms with a secondary partner. • Cultural factors specific to Hispanic Culture. • Discomfort w/sexuality an important predictor of lower self-efficacy to use condoms.	To promote condom use w/secondary partners, providers should recommend that Hispanic men: • Carry condoms • Teach specific skills such as how to use condoms under difficult conditions • Lower sexual discomfort by providing basic information about sex in a sex-positive climate • Give special attention to emotionally troubled men • Emphasize personal vulnerability to HIV for men w/ a STD • Point out that "most" men use condoms w/secondary partners	• This study failed to find differences between men in the Northeast and Southwest US, or between ethnic subgroups, education, income or age groups. • Data is cross-sectional in nature, w/ current measures of psychosocial variables being used to "predict" past behavior. • Generalizability limited by lack of telephones in some Hispanic households.

Multiple Heterosexual Partners and Condom Use Among Hispanics and Non-Hispanic Whites.
Van Oss Marin B; Gomez CA; Hearst N.
Family Planning Perspectives, 1993 Jul-Aug, 25(4):170-4.

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• Stratified clustered random digit dial telephone sampling strategy (modified two-stage Mitofsky-Waksberg) in nine States with concentrations of Hispanics ranging from 5% to 38% (NY, NJ, MA, CT, CA, AZ, CO, NM). • Telephone Interviews conducted w/ 2221 adults aged 18 to 49 years, 1592 Hispanics and 629 non-Hispanic whites. • Response Rate: 58%	• Hispanic: Women: n = 624 • Mean age: 30.3 • Acculturation (%): Low (28.9) Med (39.8) High (31.3) • Married: (59.9%) Men: n = 968 • Mean age: 29.9 • Acculturation (%) Low (37.5) Med (32.5) High (29.9) • Married (53.1%)	Multiple Sexual Partners: • 18% married Hispanic men reported 2 or more partners. • 5% Hispanic women reported 2 or more male partners. • 23% Hispanic women reported no partners. • Unmarried more likely to report two or more heterosexual partners than those currently married. • Condom Use Half of each group always used condoms w/ their secondary partners. • 49% Hispanic men and 46% Hispanic women w/ multiple heterosexual partners more likely to always use condoms w/ their secondary partners.		• Being unmarried strongly predicted having multiple partners. • Acculturation a predictor of multiple partner status:-less acculturated men and more highly acculturated women more likely to report multiple heterosexual partners. • In this study, region rather than ethnic subgroup was predictive of multiple sexual partners.	• May prove more efficient and cost-effective for prevention programs to focus on promoting consistent condom use with secondary partners. • Empower Hispanic women in a steady relationship to protect themselves with condoms. • HIV prevention programs will have difficulty promoting condoms for primary partners even with intensive one-on-one counseling. • High proportion of condom use w/ secondary heterosexual partners suggests a very different pattern of condom use when disease prevention, rather than contraception, is a primary goal.	• Self-report of sexual behavior may not be fully accurate. • Data most generalizable to Hispanics in 9 states in the Northeast and Southwest only.

Acculturation and Gender Differences in Sexual Attitudes and Behaviors: Hispanic vs. non-Hispanic White Unmarried Adults.
Marin BV; Tschann JM; Gomez CA; Kegeles SM.
American Journal of Public Health, 1993 Dec, 83(12):1759-61.

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• Interview of a random probability sample of unmarried adults who reported no homosexual or bisexual behavior in the 12 months prior to the interview and self-identified as either Hispanic (N = 398) or white (N = 540). • Sample drawn from 16 census tracts of San Francisco. • Response Rate: 64%	• Currently unmarried men and women. • Ages: 20 - 44	• Over one-third of the Spanish-speaking men and half of the English-speaking Hispanic men reported multiple partners. • Condom use was low in all groups, but Spanish-speaking Hispanic women reported lower condom use than white women. • Hispanics, generally, had poorer attitudes toward condoms and were less likely to believe they can avoid AIDS than non-Hispanic whites.		• Ethnicity/language, gender and their interaction are predictors of Partner Type. • Among Hispanics, acculturation is an important predictor of many health-related behaviors.	• There is a need for special campaigns in Spanish to address attitudes and beliefs of Spanish-speaking men and women. • Consideration of gender and acculturation are important in understanding and addressing sexual behaviors among Hispanics.	• Study may only be generalizable to Hispanic and non-Hispanic whites who are young, unmarried and living in urban areas. • Problems generalizing to Hispanic subgroups other than Mexican and Central American groups.

AIDS Prevention Among Hispanics: Needs, Risk Behaviors, and Cultural Values.
Gerardo Marin, PhD
Public Health Reports, September- October 1989; 104(5)

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• This report describes the Hispanic population's areas of greatest need in AIDS prevention and identifies Hispanic-cultural characteristics that prevention strategies must reflect.	As of 1988: • Hispanics represent 8.1% of US population. • 15% of reported AIDS cases among Hispanics. • 53% of Hispanic men w/AIDS are homosexual or bisexual non-IDUs.(In San Francisco: 93% Hispanic AIDS cases among homosexual and bisexual men.) • In San Francisco, 14% of Hispanic patients. in treatment for IV drug use found to be HIV+. • 34% of Hispanic men w/AIDS are heterosexual IDUs.	• There is a pattern of very low use of condoms among Hispanics. • The cultural value of machismo promotes sexual intercourse w/prostitutes to demonstrate virility and as a way of achieving sexual satisfaction.	Hispanic IV drug users are difficult to reach by conventional methods because treatment prevention services usually are neither culturally appropriate nor available.		• Hispanic men who have sex w/men may not consider themselves homosexual and therefore may reject or discount messages targeted specifically to homosexuals. • Problems in promoting the use of condoms by Hispanics are their association w/ prostitution and uncleanliness and perceived diminished sensation, discomfort, or inconvenience. • Prevention campaigns need to include such Hispanic cultural values as simpatia, familialism, personalismo, and power distance. • Conditions such as racism and ethnic prejudices need to be addressed that keep many Hispanic homosexuals and bisexuals away from white or non-Hispanic gay organizations and publications. • Prevention interventions need to consider using culture-specific values and norms, disseminating information in terms that are appropriate for Hispanics, and using channels of information that are accessed by them.	

Effects of Acculturation on Knowledge of AIDS and HIV Among Hispanics
Barbara V. Marin and Gerardo Marin
Hispanic Journal of Behavioral Sciences; May 1990; 12(2): 110-112.

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• A random-digit-dialing survey using a modified Mitofsky-Waksberg sampling technique was conducted of Hispanics residing in areas of San Francisco with 10% or more Hispanic population in 1988. • A total of 460 San Francisco Hispanics were interviewed.	• Mean age: 34.4 • Males: n = 184 Females: n = 276 • Born outside US: 76% • Ethnicity: Central Am. (53%) Mexican Am. (29.7%) Puerto Rican (5.1%) • Acculturation (%): Low: (73.0)			• Higher levels of education were associated with correct knowledge about AIDS and HIV transmission. • Hispanics who are less acculturated most often reported a belief in casual transmission.	• Campaigns that seek to educate the Hispanic community about HIV should target messages to less acculturated Hispanics (those most likely to speak Spanish, use Spanish-language media, and have Hispanic friends) and should emphasize the ways in which HIV is not transmitted and the latent nature of the virus. • 13% of SF Hispanics report receiving injections of medicines or vitamins outside of medical settings perceive less of risk of transmission w/ these injections than w/ injecting illegal drugs.	• Information levels regarding AIDS may be different in other Hispanic subgroups and in other cities. • Generalization to Hispanics in SF must be done cautiously because, although 92% of Hispanics in SF have telephones, it is likely that the 8% who do not would be poorer and somewhat less well educated and less acculturated than the sample as a whole. • Little is known about those refusing to participate in this study, but their attitudes toward AIDS probably influenced their refusal in many cases.

Report on a Tracking Survey of AIDS Knowledge, Attitudes and Behaviors in San Francisco's Latino Communities.
Fairbank, Bregman & Maullin, Inc.
March 10, 1989

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• A total of 329 Latino residents of San Francisco were interviewed in person during the period November 5 - December 15, 1988. These results were then compared, where applicable, to a 1987 study, "A Baseline Survey of AIDS Risk Behaviors and Attitudes in San Francisco's Latino Communities." • Using 1980 US Census block and tract data, FB&M selected a random sample of locations with high Latino populations in which to conduct the interviews. • All respondents had to meet the following criteria: - Identified themselves as Hispanic/Latino - Between the ages 18 - 60 years old. • Non-response rate: 47%	• Age (%) 18-29: 49% 30-39: 25 40-49: 13 50-59: 13 • Sex (%) Male: 48% Female: 52 • Education (%) <high school: 50% High School Grad: 28 Some college or more: 21 Refused: 1 • Household Income(5) Under $10,000: 28% $10,000-$20,000: 31 Over $20,000: 20 Refused: 22 • Marital Status (%) Married: 50% Single: 36 Separated/Divorced/ Widowed: 12 Refused: 1	• 14.3% of the respondents in 1988 had engaged in either "unsafe" sexual behavior, drug behavior, or both. • In the past month, 5% of respondents in 1988 had engaged in "unsafe" sexual behavior compared to 12% in 1987. • Nearly twice as many people had "vaginal sexual relations with a condom" in 1988 (25%) as in 1987 (14%). • Fewer people engaged in "anal sexual relations when you do not use a condom" in 1988 (2%) than in 1987 (6%). • 31% of 1988 respondents said they had engaged in vaginal sexual relations with a condom during the past year. • 6% in 1987 and 5% in 1988 had two or more sexual partners in the previous month. • Men were more likely than women to have multiple sexual partners in both the previous month and the previous year.	• 2% of respondents in both 1987 and 1988 had ever engaged in "unsafe" intravenous drug use. • Approx. 1 in 5 (19%) had been "high" or "under the influence" of alcohol, marijuana, cocaine or some other drug during sexual activity w/in the past year. • 23% of these people said they were then less likely to use a condom those times that they were "under the influence." • 4% of all respondents were "under the influence" of some drug during sexual activity and less likely to use a condom at such times in the previous year.	• 1988 proportions of "unsafe" behavior w/in past year were higher among: • Those who had changed behavior because of AIDS • Single, divorced, separated or widowed people • Those who speak mostly English or both languages equally • Men • Those w/high school diplomas or more education • Those 18-29 years old • 1988 proportions of "unsafe" behavior w/in past year lower among: • Married people • Women • Those who said they had not changed their sexual behavior because of AIDS • Those 40-60 years old • Those people who speak mostly Spanish • Those w/out high school diplomas • Greatest behavior change among: • Those who have engaged in some "unsafe" behavior in the past year • Those who speak mostly English • Men • Those who are not currently married • People between 18 and 29 years old	• Communication about AIDS must be colloquial Spanish, not an Anglo's translated version from English into textbook Spanish. • More recently developed Spanish language programs and materials are reaching more people and this must continue. • We recommend the establishment of an advisory board comprised of Latino health care providers, media representatives, and representatives of community groups to assist in the development of community education materials. • More extensive programs must continually be made available to the health centers, hospitals, clinics, schools and other institutions serving the Latino community, and community resources must be fully utilized.	

Condom Use in Multi-Ethnic Neighborhoods of San Francisco: The Population-Based AMEN (AIDS in Multi-Ethnic Neighborhoods) Study.
Joseph A. Catania, PhD, Thomas J. Coates, PhD, Susan Kegeles, PhD, Mindy Thompson Fullilove, MD, John Peterson, PhD, Barbara Marin, PhD, David Siegel, MD, MPH, and Stephen Hulley, MD, MPH
American Journal of Public Health, February 1992; 82(2):

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• Household probability sample of unmarried men and women 20 to 44 years in 16 census tracts characterized by high rates of STDs and admission to drug programs; similar proportions of Black, White, and Hispanic residents; and proximity to areas of high HIV seroprevalence. • 4234 households were contacted, 2755 met survey criteria, and 1770 volunteered.	• Specific Breakdown (%) (n = 1770): Men: 49.7 Women: 50.3 • White: 41 African American: 26 Latino: 25 Other : 8 • Median Income: $18,000 • 3% less than high school education • Only sexually active included (n = 1229) (%): White: 42 African American: 32 Latino: 26 Heterosexuals (%): Men: 44 Women: 47	• Unmarried heterosexuals were poor condom users. • Those w/multiple sexual partners were least likely to be using condoms. • Black and Hispanic women were less likely than White women to have sexual partners who always use condoms.	• Findings are limited in that the results are based on cross-sectional design - authors unable to estimate condom use levels for non respondents or differentiate condom use for birth control from that for disease prevention.	• Sexual communication skills are a key influence on condom use across social strata. • Perceived effects of condoms on sexual pleasure was a consistent influence on condom use across social strata.		• Results based on a cross-sectional design, and unable to estimate condom use levels for non respondents or differentiate condom use for birth control from that for disease prevention.

Risk for AIDS in multiethnic neighborhoods in San Francisco, California. The population-based AMEN Study. Fullilove MT; Wiley J; Fullilove RE 3d; Golden E; Catania J; Peterson J; Garrett K; Siegel D; Marin B; Kegeles S; et al. Western Journal of Medicine, 1992 Jul, 157(1):32-40.

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• Target population defined as: currently unmarried men and women, aged 20-44 at initial contact, living in 16 census tracts of San Francisco. • Tracts characterized by: -high rates of reportable sexually-transmitted diseases among women -high rates of admission to drug detox programs -roughly equal numbers of black, white and Hispanic residents. • 4234 households were contacted, 2755 met survey criteria, and 1770 volunteered.	• Gender: Men (%): 77.0 Women (%): 78.0 • Age: Men: White: 397 Black: 167 Hispanic: 240 Other: 76 Women: White: 339 Black: 289 Hispanic: 195 Other: 67 • Income: $0-5,999: 414 $6-17,999: 664 $18-29,999: 442 $30-49,999: 194 $50,000 +: 45 • Education: Less than HS: 246 HS Grad: 374 Some College: 650 College Degree: 307 Postgraduate: 181	• Homosexually active men and injection drug users reported higher rates of all the other risk behaviors than the rest of the population. • One or more risk behaviors in the past year: • Lowest among Hispanic women (5%) • Highest among white women ((21%) • The study shows that HIV infection in SF has occurred predominantly among homosexually-active men, secondarily among injection drug users, and hardly at all in the rest of the population. • Prevalence of risk behaviors across race/gender subgroups of people who are neither homosexually-active men nor injection drug users ranges from 5% to 21%.		• Having a sex partner who used injection drugs. • Having unprotected sex w/ more than four partners in the past year. • Among women, having a homosexually active male partner.	• Prevention efforts need to be redoubled among individuals who engage in risk behaviors and who fail to perceive (or who deny) the degree to which they are at risk.	• These behavioral data underestimate true levels of risk behavior. -some may under-report behaviors they perceive to be embarrassing. -some may not be aware of their risk status.

Correlates of HIV risk behaviors in black and white San Francisco heterosexuals: the population-based AIDS in multiethnic neighborhoods (AMEN) study.
Peterson JL, Grinstead OA, Golden E, Catania JA, Kegeles S, Coates TJ
Ethnicity and Disease, 1992 Fall, 2 (4): 361-70.

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• Target population defined as: currently unmarried men and women, aged 20-44 at initial contact, living in 16 census tracts of San Francisco. • Tracts characterized by: -high rates of reportable sexually-transmitted diseases among women -high rates of admission to drug detox programs -roughly equal numbers of black, white and Hispanic residents. • 4234 households were contacted, 2755 met survey criteria, and 1770 volunteered.	• Gender: Men: n = 320 Women: n = 396 • Mean Age (years): Men: 30.4 Women: 30.5 • Race (%): MEN: White: (49) Black: (80) Hispanic: (82) WOMEN: White: (42) Black: (39) Hispanic: (19) • Income (%): MEN: < 12,000: (35) 12-39,999: (55) 40+: (10) WOMEN: < 12,000: (43) 12-39,999: (51) 40+: (6)			Consistent condom use is related to: • labeling one's past sexual behavior as "risky" for HIV transmission • perceiving condoms as enhancing or at least not interfering with one's sexual enjoyment • having a strong commitment to use condoms • having good sexual communication skills	• Interventions that focus on condom enjoyment, social skills training, and commitment issues may not be sufficient to increase condom use w/out also taking into account gender differences in the meanings that condoms and sexual assertiveness have for sexual partners.	• Did not examine social norms, social support, and help-seeking contingencies, which have been hypothesized to influence problem labeling, condom commitment, and condom use.

NATIVE AMERICAN

KABB Behavioral Summaries:

1. A Survey of AIDS Knowledge, Attitudes and Behaviors in San Francisco's American-Indian, Filipino and Latino Gay and Bisexual Male Communities.
   Prepared for the San Francisco Department of Public Health, AIDS Office by Fairbank, Bregman & Maulin, Inc. May 15, 1991.

2. Frameworks for Change. Report of the Multicultural Liaison Board.
   California State Office of AIDS
   Working Draft
   July 1994

3. Native American AIDS Project
   Summary of Three Focus Groups of Native American Women in Drug Treatment Programs.

4. Preliminary Findings of Research Regarding the Sexual Identities, Attitudes & Behaviors of Native American Men Who Have (or have had) Sex With Other Men Residing in the Eastern Upper Peninsula of Michigan.
   The AIDS Task Force of Chippewa County & Algoma District, Inc.

5. American Indian/Alaskan Native Tribal and Village HIV-1 Policy Guidelines.
   National Native American AIDS Prevention Center
   May, 1991

6. Assessing the HIV-Prevention Needs of Gay and Bisexual Men of Color.
   The United States Conference of Mayors, The United States Conference of Local Health Officers.
   December 1993

NATIVE AMERICAN

Behavioral Summary

There is very little research on the behaviors of Native Americans. To date there have been no behavioral studies or even KABBs conducted in any San Francisco Native American Communities other than the KABB that sampled gay/bisexual American Indian men . Even the population estimates provided by census data are probably inaccurate since many Native Americans in California have Spanish surnames and are classified as Latino and many do not self identify as Native American to outsiders.

Because of the seeming invisibility of the Native American community in the eyes of mainstream culture, there exist two significant factors which make behavior change among high-risk Native Americans an extremely difficult task. They are insufficient funding and denial with Native American communities that HIV/AIDS poses a real threat. However, in spite of these factors, HIV has become a significant health threat within this community, particularly among men who have sex with men. According to the Centers for Disease Control, at least 79% of current AIDS cases among Native Americans are men who have had sex with other men.

The behavioral risk of these men is extremely high. A 1991 study of American Indian males in San Francisco revealed that 20% of those surveyed engaged in unprotected anal intercourse with other males, 73% indicated only occasional condom use, 68% reported difficulty talking to partners about condoms, 15% admitted daily alcohol use and 68% were unemployed. A San Francisco KABB of American-Indian, Filipino and Latino Gay and Bisexual Men found that 73% of American Indians reported using condoms only sometimes and 68% had difficulty talking about condoms with their sexual partners.

Reaching these men with HIV prevention messages is also extremely difficult due to the closeted nature of same-sex activity in this community. Compared to other populations, Native men are far more secretive about their homosexual feelings and behaviors. Over 95% believe "the part of me most people are least likely to know is my sexual orientation." The great majority have not revealed their sexual orientation to parents, siblings or other relatives. They go to considerable lengths to keep their sexual orientation concealed: hiding things when visited, watching what they say when anyone is within earshot.

A series of focus groups on the needs of Native American Women were conducted by the Native American AIDS Project. The focus group findings reveal that Native American Women are extremely reluctant to seek services within their own community due to a fear of stigmatization and a deep-rooted mistrust of the Indian Health Service around issues of confidentiality. The main problem stated by the group participants was their fear of testing for HIV or other STDs in their communities. Many of the participants shared experiences where confidential health information had been disseminated in their communities without their permission.

Recommendations for Prevention

In the Native American community there is a disproportionately high number of unemployed, poor and homeless gay and bisexual men. Community groups providing assistance to these people can be conduits for AIDS prevention information. Community groups which serve the gay and bisexual American-Indian community are more likely to have the respect and trust of the people they serve.

Due to the fear of coming out publicly about their sexual orientation and the resulting low self-esteem that results, programs that will be effective for gay and bisexual Native American men should follow an empowerment model. It has been found that individual empowerment results in increased self-efficacy and motivation to exert control. Equally important for these men are programs that introduce community empowerment strategies. A report of the United States Conference of Mayors states that " Individual empowerment linked to community empowerment becomes the route for gay and bisexual men of color to challenge their internalized powerlessness while also developing real opportunities to gain control in their lives and transform their various settings - specifically, implement and support individual and collective behavior change to reduce their risk of HIV infection."

The Multicultural Liaison Board found that the tendency of funding sources to provide monies for education "target groups" is incompatible with the ways in which Natives view themselves as a member of a particular tribe or community. Thus education strategies which orient themselves toward the community as a whole will be most effective. The board also found that the two issues having the biggest impact on HIV education were substance abuse and poverty. In relation to substance abuse, the most urgently needed intervention in increased communication and coordination between HIV and substance abuse programs, as well as improved funding for substance abuse centers.

The Multicultural Liaison Board also found that due feelings of invisibility as a community and a history of feeling that their needs are always put on the "back burner", HIV prevention programs face formidable barriers.

HIV prevention needs to be provided in a cultural context that people can identify with and feel proud of. Such prevention also must be integrated into other life issues and problems since there is a disproportionately a high number of unemployed in the community.

Recommendations for Future Research

Native American populations are often lumped into an "other" category for research purposes. This ignores the diversity of this community and blurs the many distinctions that would add to HIV prevention efforts. In order to understand and utilize these distinctions, research needs to be conducted that highlights the vastly different histories, cultures, languages, and current status of each tribe (federally recognized or not.)

To date, there are very few studies that have looked at Native American gay men as a distinct population. For HIV prevention efforts to have a lasting impact among this population, research efforts need to be focused on identifying the cultural factors that influence sexual behaviors and risk taking in general. This research should be extended to heterosexual Native Americans as well.

A Survey of AIDS Knowledge, Attitudes and Behaviors in San Francisco's American-Indian, Filipino and Latino Gay and Bisexual Male Communities. Prepared for the San Francisco Department of Public Health, AIDS Office by Fairbank, Bregman & Maulin, Inc. May 15, 1991.

1. Summary of Results: American-Indian Gay/Bisexual Male Survey

Study design, sample size and method, entry criteria, year of sample.	Sample Demographics	Sexual Behaviors	Drug-using Behaviors	Predictors	Implications for Prevention	Limitations
• Chain referral, convenience sample. Respondents located at clubs, gay bars, health agencies, etc. • 60 interviews conducted among American Indian respondents. • 106 interviews conducted among Filipino respondents. (Filipino respondents were given the option of completing the interview in Tagalog or English.) • 100 interviews conducted among Latino respondents. (Latino respondents were given the option of conducting the interview in Spanish or English.) • Interviewing was conducted during the period June through October, 1990.	• 40%: raised on a reservation or mostly Indian community. • Age range (%): 30-34: 50% 35-39: 23% 25-29: 18% • Education: Not HS grad: 7% HS grad: 43% Some college or vocational school: 38% College grad/professional school: 9% • <$10,000: 60% $10,000 to $20,000: 27% Currently unemployed: 68% • Gay identified: 90% Bisexual: 2% Straight: 2%	• 20%: reported unprotected anal intercourse with a male partner. • 73%: reported using condoms only sometimes. • 68%: report having difficulty in talking about condoms with their sexual partners.	• 13%: reported sex under the influence of alcohol or another drug. • 27%: reported marijuana use. • 2%: reported injecting cocaine and speed or some other amphetamine.		• Gay men of color hear and see the information disseminated in the majority community, but do not necessarily respond to it. Community groups which serve the gay and bisexual American-Indian, Filipino and Latino communities are more likely to have the respect and trust of the people they serve. • In the American Indian community, there is a disproportionately high number of unemployed, poor and homeless gay and bisexual men. Community groups providing assistance to these people can be conduits for AIDS prevention information. • Rather than a "macro" approach to advertising using mass media, a "micro" approach, reaching people through the smaller and thus far underutilized, personal, community-centered organizations is recommended.	

Chapter 2:

Resource Inventory

CHAPTER 2: RESOURCE INVENTORY

Introduction

The CDC Guidance mandates the creation of an inventory of resources currently in use in San Francisco. In response to the Guidance, the HPPC has investigated several sources of data, including agency reports submitted to the SFDPH AIDS Office by programs funded with money from the CDC, the State of California and the San Francisco General Fund. Agency reports for programs not funded through the SFDPH AIDS Office were also collected and analyzed. Because no standardized format is available from which to develop a comprehensive inventory, however, the picture remains incomplete.

Programs funded by the CDC through the SFDPH AIDS Office are required to submit annual reports detailing their progress throughout the year. Annual reports for most CDC-funded agencies for 1993 have been incorporated in this chapter and are summarized in Appendix B. A matrix organizing the same underlying data by intervention and target population is presented in Appendix C. Programs funded through the San Francisco General Fund and through the State of California have not been incorporated into this draft due to varying reporting requirements. They will be included in subsequent revisions of this plan.

Information on programs not funded through the SFDPH AIDS Office was acquired through a questionnaire circulated to agencies identified as being privately-funded. Data for those programs is incorporated in this inventory although no dollar amounts for the cost of their services were gathered.

This chapter summarizes what providers have reported about whom they targeted and served in 1993. A draft compilation developed by the SFDPH AIDS Office shows $11,927,746 in public and private resources were spent for HIV prevention in San Francisco in 1992/1993, and $13,580,110 in 1993/1994 (Appendix A).

Limitations

The lack of a central resource for data concerning prevention resources prevents this chapter from reflecting a complete review of HIV prevention services in San Francisco. In general, data on prevention resources is available only to the extent that it is required by funders, and therefore varies according to funding source.

Evaluation and reporting requirements of funders, when they exist, typically focus on measurements and evaluations of process objectives. Demographic

data on clients is not mandated under these reporting requirements unless it directly relates to the assessment of process objectives.

The reporting regimen is sufficient to evaluate process goals, but leads to significant under-counting for populations that were served but not specifically targeted. For example, a program funded to provide services to gay and bisexual men in general might not have reported how many of its clients were white or African American, or were injection drug users (IDUs). This under-counting effect is most extreme for populations that may have been widely served (e.g., Caucasian gay men) but rarely if ever specifically targeted in relation to their race. Thus, data that could appear to show gaps in services may, in fact, be erroneous and only reflect gaps in knowledge about who was served.

Recommendations

Ensuing assessment of HIV prevention resources in San Francisco will benefit from changes in data collection. Therefore, the HPPC recommends the following:

- The protocols used for program proposals and applications for funding must correlate with evaluation or annual report forms, so that a coherent analysis can be made of whether or not programs achieved their intended purpose.

- Double-counting of populations and clients served must be avoided , so that reliable numbers regarding populations served can be generated.

- Reporting requirements should be standardized regardless of source of funding.

Program Resources by Target Populations

The reported demographic data on who was served in 1993 cannot support an inference about who was not served. Moreover, because the inventory is organized by target population, services for individuals who fall into more than one target population are counted twice. As an example, services for gay and bisexual male substance users are included in separate gay and bisexual men and substance user inventories. In spite of these under-counting and double-counting issues, however, general conclusions can be drawn from available data about the resources currently available for HIV prevention in San Francisco.

African Americans

Several agencies reported providing services to African Americans, including gay and bisexual African American men and African American substance users. Services provided included risk reduction education workshops for clients from the Western Addition; special events for gay and bisexual men; multi-session group meetings for substance users and others; street outreach directed toward women, youth, substance users and high-risk heterosexuals; risk assessment and pre-testing counseling for substance users and others; post-test counseling for substance users; case management services for substance users; and partner notification assistance. No organization reported providing media campaigns for African Americans.

Street outreach reached the largest number of African Americans, including more than 1,000 out-of-treatment substance users, almost 3,000 high-risk heterosexuals, more than 1,100 women and more than 500 high-risk youth. In general, almost all outreach and group education programs targeting African Americans reported reaching or exceeding their service objectives. Programs offering testing and counseling, case management and partner notification services were less successful in meeting their objectives.

Asian/Pacific Islanders

A number of organizations reported serving Asian/Pacific Islander clients. One organization specifically targeted the Filipino community. Services provided included risk reduction education workshops including some services specifically targeting subgroups of women, youths and gay and bisexual men; community meetings and forums targeting the community at large and women; outreach including some services specifically for gay and bisexual men; and outreach to a number of media outlets serving the community at large and the Filipino community in particular. A small number of community members also received individual risk assessment education sessions and individual case management services.

Most programs targeting the Asian/Pacific Islander community reported success in achieving process objectives. Outreach and community forums reached the largest number of individuals. Outreach to the Filipino community was especially intense, with two organizations serving this subgroup.

Latinos

Groups reporting serving the Latino community provided the following services: single-session risk reduction education workshops including some services specifically for women; multi-session education workshops for women, youths and immigrant gay and bisexual men; ongoing support workshops for immigrant gay and bisexual men; outreach to women; risk assessment and education sessions for immigrant gay and bisexual men; and community organizing, advocacy and education services targeting women.

Organizations serving the Latino community reported achieving most of their process objectives.

Native Americans

A few agencies reported providing services to the Native-American community including gay and bisexual men and substance users. Services included: prevention case management; health education/risk reduction programs; street outreach; advocacy; and broad community-level interventions.

Gay and Bisexual Men

A number of organizations reported serving gay and bisexual male members of other target populations defined by ethnicity or other risk behavior. Gay and bisexual men who were not reported to belong to other target populations also were served. Specific services included risk reduction and education workshops including some services targeted specifically for Asian/Pacific Islanders; special events for African American gay and bisexual men; outreach to young gay and bisexual men; a hotline for youth; multi-session education workshops for immigrant Latino men and substance users; ongoing support workshops for immigrant Latino men; outreach including some services specifically targeted to Asian/Pacific Islanders and gay men under age 26; risk assessment and education sessions for Latino men, youth and substance users; pre-test counseling and testing for substance users; case management for substance users; referrals for care including services specifically targeted for substance users; partner notification services for substance users; and media including some services targeting Asian/Pacific Islander men.

Programs offering outreach services and education workshops generally were successful in meeting process goals, while programs providing testing and counseling, case management and referrals were less successful.

Women

Organizations targeted women of color, incarcerated women and other women at high risk for transmission of HIV providing the following services: risk reduction education groups for African American, Latina, Asian/Pacific Islander and incarcerated women and other women at risk; community meetings and forums for Asian/Pacific Islanders; multi-session workshops for Latina adults and youth; ongoing support workshops for African Americans; outreach to Latinas, African Americans and Asian/Pacific Islanders; risk assessment and education sessions for African Americans, Asian/Pacific Islanders and women at high risk; and community organizing, advocacy and education services for Latinas.

Several programs for women tied HIV prevention into prevention of other sexually-transmitted diseases. Almost all of the programs targeting women met their objectives. Workshops for incarcerated women stood out in terms of exceeding objectives, serving more than 4,300 women.

Youth

Programs targeted a variety of subgroups among youths, including youths of various ages, youths of color, youths both in and out of schools, youths in detention and sexually-active youths. Services provided included risk reduction education workshops for parents and middle-school-age children, sexually active African American teenagers, Asian/Pacific Islanders, out of school youths, gang members, young IDUs, and gay and bisexual men under age 26; forums for Asian/Pacific Islanders; multi-session education workshops for high school, middle school, higher-risk and Latino youths; ongoing support workshops for sexually active African American youths and youths in detention; outreach to youths in detention, high-risk African American youths, out of school youths, gang members, young IDUs and gay and bisexual men under age 26; a telephone hotline for lesbian, gay, bisexual, transgendered and questioning youth age 23 and under; risk assessment and education sessions for youths in detention, sexually-active African American teenagers, out of school youths, gang members, young IDUs and Asian/Pacific Islanders; and pre-test counseling and HIV testing for youths in detention.

Almost all of the programs targeting youths met their objectives, with outreach programs in schools, programs for youths in detention and outreach/hotline programs reaching the largest numbers of youths.

Substance and/or Injection Drug Users

A number of programs targeted substance/IDUs including IDUs of color and gay and bisexual male substance users. The following services were reported: risk reduction workshops for African American substance users and young IDUs; multi-session education workshops for gay and bisexual men, African Americans and others seeking outpatient services; ongoing peer support workshops for African American substance users; outreach to out-of-treatment African American substance users and young IDUs; risk assessment sessions including some services targeted for gay and bisexual men, IDUs in the Western Addition, Tenderloin and Mission districts, methadone treatment patients or African Americans; pre-test counseling and HIV testing including some services specifically targeting gay and bisexual men and African Americans; post-test counseling and case management including some services specifically targeting African Americans; and partner notification services for gay and bisexual men.

Compared to programs for other target populations, somewhat fewer programs targeting substance users and IDUs met their process objectives. A relatively large number of separate programs targeted this population, however.

Partners of IDUs

Several programs targeted partners of IDUs, providing the following services: risk assessment and education workshops; counseling and testing including some services targeting partners of gay and bisexual men and African Americans; and outreach. These programs generally met their objectives, although the number of clients served was small.

Incarcerated Individuals

One program reported providing incarcerated people with risk reduction workshops, testing and counseling, post-test counseling and outreach materials.

Other

Several programs provided services for individuals who were not identified as belonging to a target population, including risk reduction education sessions, testing and counseling for more than 5,300 individuals. One service provided HIV treatment information to people with HIV or AIDS, people at risk, families and friends, and medical and service providers.

BARRIERS TO ACHIEVEMENT OF GOALS FOR 1993

Most HIV prevention programs reported meeting their process objectives. Programs that failed to meet their objectives noted a variety of impediments.

Funding

By far the most common barrier was decreased funding. The lack of money impacted service providers in a number of ways.

Funding cuts resulted in staff numbers that often were inadequate to meet stated goals and objectives. There was simply no one there to render services or intervention. This situation occurred at the several agencies.

Decreased funding also caused agencies to simply cancel certain programs. Of course, a canceled program cannot meet its objectives. For instance, when one agency was forced to close its methadone detox center for five months, that closure impacted completion of three of its six service objectives.

When an agency is faced with a smaller budget, downsizing becomes a necessity. The change in organizational size also results in restructuring the management/administration of the agency. Many agencies were slow to begin their programs due to the needed adjustment time budgetary changes required.

Although most agencies put on a good face and provided services or intervention with vigor and determination, it is clear from their reporting that funding cuts impacted staff morale and depleted necessary materials for conducting an effective campaign in AIDS/HIV intervention.

Cultural Attitudes

Prevention providers said cultural attitudes kept them from achieving some service goals. The cultural or religious beliefs of many communities make education about AIDS and HIV risk very difficult. In particular, providers said the cultural norms and beliefs of the Asian and Pacific Islander communities posed significant barriers in combating the spread of AIDS. The stigmatization of sexuality, homosexuality, substance use, illness and death have resulted in a high level of denial within these communities about their risk for HIV infection.

Other factors that providers said limited the Asian and Pacific Islander communities to this information include: lack of familiarity among Asian and Pacific Islanders with the American health care system; the segmentation of life roles for gay Asian and Pacific Islanders, which contributes to their

reluctance to seek help in the early stage of infection; and the strong tradition of privacy and resistance to disclose information, particularly on matters related to finances and sexuality.

One agency in particular reported that these barriers were important and needed to be addressed before truly effective services could be delivered to the Asian and Pacific Islander population.

Transience of Clientele

Some agencies said the transience of their service population hindered effective interventions. For example, an agency targeting young gay and bisexual Japanese nationals living in the US noted that most of its clients are students. During the late summer and early autumn months, these clients return to Japan or travel abroad. All of its group education activities therefore were scheduled to occur in the second quarter after the academic year began. The program was designed to reach the population when they were available in this country, but could not offer complete follow-up because the population is not available year-round. Transience also was identified as a barrier to implementing programs serving substance users.

Attracting Clients

Some agencies reported that services were not able to attract the desired number of clients. Problems typically related to publicity and program design.

For example, although several programs were designed to give counseling and testing to partners of HIV-positive individuals, these programs were often undersubscribed. One agency in particular noted that communication with partners of HIV-positive individuals was a problem.

A similar problem was noted by an agency providing training workshops to prevention providers. According to this agency, on several occasions training announcements were not sent out early enough to assure good attendance. In addition, even though the training topics were selected by agency provider staff, some of the topics turned out to have limited interest.

Hiring and Retaining Appropriate Staff

Although funding cuts caused many staffing problems, however, other staffing shortfalls related to a limited number of qualified staff. For instance, most of the agencies who needed the services of bilingual staff mentioned the difficulties around hiring and retaining good bilingual staff. Nurses also were in short supply, an agency offering counseling and testing noted.

Staff turnover also caused disruptions that impacted delivery of services. The time between the departure of the former staff and the complete training of the new staff often disrupts services and an agency's administrative rhythm.

CONCLUSION

San Francisco prevention providers offered a variety of interventions to targeted populations. However, data collected to date does not provide a complete picture of HIV prevention resources and gaps in San Francisco due to the limitations previously outlined. On-going assessment of available resources will assist in identifying efficacy and gaps in HIV prevention programs and services.

Note: This chapter includes information from the following sources:

- 18th Street Services
- Asian AIDS Project
- Asian American Communities Against AIDS (AACAA)
  Japanese Community Youth Council
- Bayview Hunter's Point Foundation
- California AIDS Intervention Training Center
- Coalition for Immigrant and Refugee Rights and Services
- Community Substance Abuse Services Coordination HIV Prevention in Drug Users
- Filipino Task Force on AIDS
- Forensic AIDS Project
- GAPA Community HIV Project APICA
- Glide Goodlet AIDS Project
- Haight Ashbury Free Clinic
- Haight Ashbury HIV Prevention Outreach Project
- HIV Community Health Outreach Services for HIV Prevention in Drug Users
- Horizons Unlimited

- Instituto Familiar De La Raza
- Iris Center
- LYRIC
- National Task Force on AIDS Prevention
- PHREDA Project
- Planned Parenthood
- Project Inform
- San Francisco City Clinic Health Education/Risk Reduction
- San Francisco Dept. of Public Health, San Francisco City Clinic HIV Counseling and Testing Service
- San Francisco Unified School District
- Stop AIDS
- UCSF AIDS Health Project
- Urban Health Study
- Wedge Program
- Westside Inner-City Outpatient Services
- Westside Methadone Treatment Program
- Youth Guidance Center

Chapter 2:

Resource Inventory

Appendix A:

Matrix of San Francisco HIV Prevention Resources for 1992 / 1993 and 1993 / 1994; Compiled by SFDPH AIDS Office

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HIV Prevention In San Francisco (Based on 93/94)

January 6, 1994

#	Program Name	Amount (1)	S/(2)	TYPE OF INTERVENTION (3)								TARGET ETHNIC GROUP					TARGET RISK GROUP (4)			
				CLI	HERR	PCM	SCI	PI	C/T	TRAINING	ADMIN/ R&E	AFRICAN AM	LATINO	ASIAN/PI	NATIVE AM	CAUC	GAY/BI	IDU/SU	YOUTH	FEMALE PART of IDUs
1	18th Street	$100,856.04	G		$100,856							$30,257	$25,214	$2,017	$3,026	$40,342	$50,428	$50,428		
2	18th Street	$75,000.00	S				$75,000					$9,000	$24,000		$3,000	$39,000	$25,000	$25,000	$25,000	
3	18th Street	$40,000.00	C						$40,000			$0	$11,440	$0	$0	$28,560	N/A	N/A	$2,920	N/A
4	AAP	$298,078.00	S	$298,078								$745	$1,043	$296,290			$225,347	$72,731		
5	AAP	$112,500.00	S	$56,250	$56,250							$281	$394	$111,825			$112,500			
6	AAP	$75,520.42	G		$75,520							$189	$264	$75,075			$75,520			
7	AIAE	$82,000.00	S	$41,000	$41,000										$82,000			$82,000		
8	AIAI	$54,515.22	G	$54,515											$54,515		$27,258		$27,258	
9	AIAI	$35,652.97	G		$35,653										$35,653		$17,826		$17,826	
10	BCA	$178,523.84	G	$178,524								$178,524					$44,631	$44,631	$44,631	$44,631
11	BCA	$125,000.00	S	$125,000								$125,000					$31,250	$31,250	$31,250	$31,250
12	Brothers	$140,698.73	G	$140,699								$140,699					$140,699			
13	Brothers	$122,294.28	G		$122,294							$122,294					$122,294			
14	BVHPF	$66,744.89	G			$66,767						$66,767						$26,707	$23,368	$10,692
15	BVHPF	$45,000.00	C						$45,000			$20,800	$10,400			$33,800	N/A	N/A	$4,745	N/A
16	BVHPF	$47,547.57	G		$47,568							$47,568						$19,027	$18,649	$11,892
17	CAITC	$250,000.00	S							$250,000										
18	CAITC	$76,884.28	G		$76,884							$76,884					$19,972	$19,972	$19,972	$19,972
19	CCHospHouse	$51,500.00	G	$25,750			$25,750					$10,300	$10,540	$1,030	$1,545	$20,065			$51,500	
20	CSAS	$69,441.00	C								$69,441									
21	Ctr for Health Training	$30,000.00	S							$30,000										
22	CtrSEAsn Refugees	$195,447.00	C				$195,447					$48,862		$97,724		$48,862	$78,179	$58,406	$19,545	$29,317
23	CUAV	$10,868.00	G		$10,868							$1,608	$1,848	$5,923	$250	$1,239			$10,868	
24	Family Health	$181,017.00	C						$181,017			$45,254	$26,429	$54,305	$0	$44,530	N/A	N/A	$13,214	N/A
25	Forensic AIDS Project	$352,549.00	C						$352,549			$98,714	$62,401	$8,814	$4,231	$140,315	N/A	N/A	$25,738	N/A
26	GCHP	$98,955.92	G		$98,956									$98,956			$98,956			
27	GCHP	$26,172.65	G								$26,173									
28	HAFCI	$132,548.00	C								$132,548	$5,302	$5,302	$1,325	$2,651	$117,968			$132,548	
29	HAFCI	$112,115.00	C				$112,115					$45,070	$897	$14,129	$1,570	$50,452		$112,115		
30	HAFCI	$85,000.00	S				$85,000					$34,170	$680	$10,710	$1,190	$38,250		$85,000		
31	HAFCI	$70,000.00	C						$70,000			$14,700	$4,900	$3,500	$0	$46,900	N/A	N/A	$5,110	N/A
32	HAFCI	$60,780.11	G	$60,780								$24,434	$486	$7,650	$851	$27,351		$30,390	$30,390	
33	HAFCI	$34,748.25	C								$34,748									
34	HAFCI	$22,074.00	C								$22,074									
35	HAFCI	$14,907.00	C				$14,907					$5,993	$119	$1,878	$209	$6,708		$14,907		
36	HAFCV18TH ST	$103,463.00	C				$103,463					$20,693	$10,346	$5,173	$2,069	$65,182	$51,732	$51,732		
37	HAFCV18TH ST	$29,872.00	C				$29,872					$5,974	$2,987	$1,494	$597	$18,819	$14,936	$14,936		
38	HAFCVAAP	$13,829.00	C				$13,829					$35	$48	$13,745			$13,829			
39	HAFCVAAP	$4,318.00	C				$4,318					$11	$16	$4,292			$4,318			
40	HAFCVAIAI	$13,828.00	C				$13,828								$13,828		$6,914		$6,914	

(1) Note: Fed Funds for 1/94-12/94, State Funds for 7/93-6/94 -> Target Group Data for 7/92-6/93; (4) Target Groups may overlap; (5) Estimates; (6) Funds terminate 12/31/93 or 3/31/94

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January 5, 1994

HIV Prevention in San Francisco (Based on 93/94)

#	Program Name	Amount (1)	$(2)	TYPE OF INTERVENTION (3)								TARGET ETHNIC GROUP					TARGET RISK GROUP (4)			
				CLI	HERR	PCM	SO	PI	C/T	TRAINING	ADMIN/ R&E	AFRICAN AM	LATINO	ASIAN/PI	NATIVE AM	CAUC	GAY/BI	IDU/SU	YOUTH	FEMALE PART of IDUs
41	HAFC/AIAI	$4,318.00	C				$4,318								$4,318		$2,159		$2,159	
42	HAFC/CAITC	$76,429.00	C				$76,429					$76,429					$19,107	$19,107	$19,107	$19,107
43	HAFC/CAITC	$22,398.00	C				$22,398					$22,398					$5,600	$5,600	$5,600	$5,600
44	HAFC/PROYECTO	$51,172.00	C				$51,172						$51,172				$51,172			
45	HAFC/PROYECTO	$15,087.00	C				$15,087						$15,087				$15,087			
46	HAFC/TARC	$85,132.00	C				$85,132					$38,480	$25,625	$1,703	$1,703	$17,622		$85,132		
47	HAFC/TARC	$21,269.00	C				$21,269					$9,614	$6,402	$425	$425	$4,403		$21,269		
48	HIV P+E:SFCC-CTS	$609,816.00	C						$609,816			$146,356	$131,110	$45,734	$6,098	$280,516	N/A	N/A	$44,517	N/A
49	HIV P+E:SFCC-CTS	$129,150.00	C							$129,150										
50	HIV P+E:SFOH	$259,203.00	C						$259,203			$98,497	$51,841	$12,960	$1,037	$94,868	N/A	N/A	$18,922	N/A
51	IFR/GELAAM	$90,304.57	G		$90,305								$90,305				$90,305			
52	Iris Center	$246,832.00	C	$246,832								$148,099	$24,683			$74,050		$98,733		$148,099
53	Iris Center	$92,293.00	S		$92,293							$55,376	$9,229			$27,688		$36,917		$55,376
54	Iris Center	$81,950.42	G	$81,950								$49,170	$8,195			$24,585		$32,780		$49,170
55	LSYC (5)	$81,236.92	G		$81,237							$12,186	$12,186	$12,186	$4,062	$40,618	$40,618		$40,618	
56	Lyon-Martin	$70,000.00	A				$35,000			$35,000		$700	$3,570	$5,740	$700	$59,290	$56,000			$14,000
57	LYRIC	$100,000.00	S		$100,000							$15,000	$22,000	$18,000		$45,000	$100,000			
58	MARC/Polaris	$240,000.00	S							$240,000										
59	Mission N Health Ctr	$131,169.00	C			$131,169							$131,169				$32,792	$52,468	$26,234	$19,675
60	NTFA-M/Color Chart	$267,943.00	C	$267,943								$132,454	$34,553	$5,759	$8,638	$106,539	$267,943			
61	NTFAP	$119,272.71	G								$119,273									
62	Operation Concern	$121,458.00	G		$60,729	$60,729						$5,223	$4,130	$2,429	$607	$109,069	$121,458			
63	PHREDA Project	$1,278,327.00	C				$1,278,327					$768,996	$255,665	$38,350	$25,567	$191,749		$191,749		$1,086,578
64	Pind Prmhd	$81,100.81	G		$81,101							$69,260	$3,447	$3,447		$4,947		$40,550		$40,550
65	Proyecto	$101,268.50	G	$101,269									$101,269				$101,269			
66	Proyecto	$86,301.83	G		$86,302								$86,302				$86,302			
67	Proyecto	$92,333.00	G	$92,333									$92,333				$92,333			
68	RAP	$135,000.00	S				$135,000					$32,535	$86,150	$9,855	$1,215	$5,265			$135,000	
69	RAP	$70,000.00	S				$70,000					$16,870	$44,660	$5,110	$630	$2,730	$70,000			
70	SFAF	$184,351.70	G								$184,352									
71	SFAF (5)	$310,639.27	G	$310,639								$46,596	$46,596	$46,596	$15,532	$155,320	$77,660	$77,660	$77,660	$77,660
72	SFAF (5)	$249,583.00	C			$249,583						$37,437	$37,437	$37,437	$12,479	$124,792	$249,583			
73	SFAF (5)	$128,478.00	G					$128,478				$19,272	$19,272	$19,272	$6,424	$64,239	$77,087	$25,696	$12,848	$12,848
74	SFAF (5)	$71,980.40	G		$71,980							$10,797	$10,797	$10,797	$3,599	$35,990	$17,995	$17,995	$17,995	$17,995
75	SFAF/Prev Point	$247,000.00	G	$247,000								$59,280	$29,640	$4,940	$4,940	$148,200		$247,000		
76	SFDPH-AO:AESOP	$355,277.00	C								$355,277									
77	SFDPH-AO:CTRPN	$276,493.00	C								$276,493									
78	SFDPH-AO:PartRel	$76,302.00	C						$76,302			$18,926	$18,926			$37,651	$26,356	$26,356	$7,530	$15,060

(1) Note: Fed Funds for 1/94-12/94, State Funds for 7/93-6/94 -> Target Group Data for 7/92-6/93; (4) Target Groups may overlap; (5) Estimates; (6) Funds terminate 12/31/93 or 3/31/94

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HIV Prevention In San Francisco (Based on 93/94)

January 6, 1994

#	Program Name	Amount (1)	S(2)	TYPE OF INTERVENTION (3)								TARGET ETHNIC GROUP					TARGET RISK GROUP (4)			
				CLI	HERR	PCM	SO	PI	C/T	TRAINING	ADMIN/ R&E	AFRICAN AM	LATINO	ASIAN/PI	NATIVE AM	CAUC	GAY/BI	IDU/SU	YOUTH	FEMALE PART of IDUs
78	SFDPH-AO:YPEP	$125,000.00	S		$125,000							$93,750	$12,500	$12,500	$3,750	$12,500			$125,000	
80	Stop AIDS	$269,463.00	C				$269,463					$53,892	$26,946	$13,473	$5,389	$169,762	$269,463			
81	Stop AIDS	$153,128.00	C	$153,128								$12,097	$16,313	$11,844	$2,603	$111,171	$76,564		$76,564	
82	Stop AIDS	$135,000.00	S	$135,000								$10,665	$13,500	$10,530	$2,295	$96,010	$135,000			
83	Stop AIDS	$126,239.59	G	$126,240								$9,973	$12,624	$9,847	$2,148	$91,650	$126,240			
84	TARC	$47,818.23	G		$47,818							$21,814	$14,393	$956	$956	$9,896		$47,818		
85	TARC	$20,464.00	G	$20,464								$9,250	$6,160	$409	$409	$4,236		$20,464		
86	UCSF/AHP	$367,204.00	C						$367,204			$22,787	$51,409	$26,439	$2,203	$264,367	N/A	N/A	$26,806	N/A
87	UCSF/AHP	$311,821.00	S						$311,821			$40,225	$29,935	$23,618	$1,871	$216,092	N/A	N/A	$22,763	N/A
88	UCSF/AHP	$148,262.74	G		$148,263							$7,313	$13,164	$2,925	$1,463	$121,398	$134,562	$11,701		
89	UCSF/AHP	$126,000.00	C							$126,000										
90	UCSF/UHS (4)	$467,124.00	C						$467,124			$252,247	$74,740	$9,342	$9,342	$121,452		$467,124		
91	WEDGE	$315,565.00	C		$315,565							$66,269	$72,590	$123,070	$2,209	$51,427			$315,565	
92	Westside	$158,200.00	C						$158,200			$31,640	$14,238	$6,328	$0	$105,994	N/A	N/A	$11,549	N/A
93	WNC	$214,000.00	S				$107,000		$107,000			$160,500	$42,800			$10,700		$107,000		$107,000
94	WNC	$66,449.98	G			$66,450						$49,837	$13,290			$3,322		$33,225		$33,225
95	YGC	$202,195.00	C		$202,195							$60,052	$27,296	$21,837	$11,121	$81,889	$8,088		$194,107	
	GRAND TOTAL:	$13,580,109.74		$2,773,413	$2,165,637	$574,696	$2,844,123	$128,478	$3,064,236	$810,150	$1,219,374	$3,059,059	$2,092,290	$1,309,002	$350,916	$3,897,390	$3,521,348	$2,414,575	$1,668,985	$1,854,697
				20%	16%	4%	21%	1%	23%	6%	9%	34%	18%	12%	3%	33%	37%	25%	18%	20%

(1) FUNDING SOURCE
A = AMFAR/PRIVATE
C = CDC/FEDERAL
G = GENERAL FUND/CITY
S = STATE

(2) KEY:
CLI = COMMUNITY LEVEL INTERVENTION
C/T = COUNSELING AND TESTING
HERR = HEALTH ED & RISK REDUCTION
PCM = PREVENTION CASE MANAGEMENT
SO = STREET OUTREACH
PI = PUBLIC INFORMATION

(1) Note: Fed Funds for 1/94-12/94, State Funds for 7/93-6/94. (3) Target Group Data for 7/93-6/94; (4) Target Groups may overlap; (5) Estimates; (6) Funds terminate 12/31/93 or 3/31/94

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City (General Fund) Funded HIV Prevention in San Francisco (Based on 93/94)

January 14, 1994

#	Program	12 Month Amount (1)	TYPE OF INTERVENTION (2) CLI	HERR	PCM	ADMIN/ R&E	TARGET ETHNIC GROUP AFR AM	LATINO	API	NAT AM	CAUC	TARGET RISK GROUP (3) GAY/BI	IDU/SU	YOUTH	FEMALE PART of IDUs
1	18th Street	$67,237.36		$67,237			$20,171	$16,809	$1,345	$2,017	$26,895	$33,619	$33,619		
2	AAP	$50,352.28		$50,352			$126	$176	$50,050			$50,352			
3	AIAI	$36,343.48	$36,343							$36,343		$18,172		$18,172	
4	AIAI	$23,768.65		$23,769						$23,769		$11,884		$11,884	
5	BCA	$119,015.76	$119,016				$119,016					$29,754	$29,754	$29,754	$29,754
6	Brothers	$93,799.15	$93,799				$93,799					$93,799			
7	Brothers	$81,522.85		$81,523			$81,523					$81,523			
8	BVHPF	$44,511.33			$44,511		$44,511						$17,805	$16,579	$11,128
9	BVHPF	$31,711.71		$31,712			$31,712						$12,685	$11,099	$7,928
10	CAITC	$50,590.85		$50,591			$50,591					$12,648	$12,648	$12,648	$12,648
11	GCHP	$65,970.61		$65,971					$65,971			$65,971			
12	GCHP	$17,448.43				$17,448									
13	HAFCI	$40,520.07	$40,520				$16,289	$324	$5,106	$567	$18,234		$20,260	$20,260	
14	IFR/GELAAM	$60,203.05		$60,203				$60,203				$60,203			
15	Iris Center	$54,633.61	$54,634				$32,780	$5,463			$16,390		$21,853		$32,780
16	LSYC (4)	$54,157.95		$54,158			$8,124	$8,124	$8,124	$2,708	$27,079	$27,079		$27,079	
17	NTFAP	$79,515.14				$79,515									
18	Open'n Concern	$80,972.00		$40,486	$40,486		$3,482	$2,753	$1,619	$405	$72,713	$80,972			
19	Plan'd Parenthd	$54,067.21		$54,067			$46,173	$2,298	$2,298		$3,298		$27,034		$27,034
20	Proyecto	$67,525.67	$67,526					$67,526				$67,526			
21	Proyecto	$57,534.55		$57,535				$57,535				$57,535			
22	SFAF	$122,901.13				$122,901									
23	SFAF	$207,092.85	$207,093				N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
24	SFAF	$47,986.93		$47,987			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
25	Stop AIDS	$84,159.73	$84,160				$6,649	$8,416	$6,564	$1,431	$61,100	$84,160			
26	TARC	$31,878.82		$31,879			$14,409	$9,596	$638	$638	$6,599		$31,879		
27	TARC	$13,642.67	$13,643				$6,166	$4,106	$273	$273	$2,824		$13,643		
28	UCSF/AHP	$97,508.49		$97,508			$4,875	$8,776	$1,950	$975	$80,932	$89,708	$7,801		
29	WNC	$44,299.99			$44,300		$33,225	$8,860			$2,215		$22,150		$22,150
	GRAND TOTAL:	$1,880,872.33	$716,733 38%	$814,977 43%	$129,297 7%	$219,865 12%	$613,622 44%	$260,965 19%	$143,937 10%	$69,126 5%	$318,279 23%	$864,903 62%	$251,129 18%	$146,475 10%	$143,421 10%

(2) INTERVENTION: ADMIN/R&E = ADMINISTRATION, RESEARCH, PROGRAM EVALUATION; CLI = COMMUNITY LEVEL INTERVENTION; HERR = HEALTH ED & RISK REDUCTION; PCM = PREVENTION CASE MANAGEMENT

(1) Note: Fed Funds for 1/94-12/94, State Funds for 7/93-6/94 -> Target Group Data for 7/92-6/93; (3) Target Groups may overlap; (4) Estimates

HIV Prevention In San Francisco (Based on 92/93)

January 19, 1994

#	Program Name	Amount (1)	S(2)	Type (3)	TYPE OF INTERVENTION (4)								TARGET ETHNIC GROUP					TARGET RISK GROUP (5)			
					CLI	HERR	PCM	SO	PI	C/T	TRAINING	ADMIN/ R&E	AFRICAN AN	LATINO	ASIAN/PI	NATIVE AM	CAUC	GAY/DI	IDU/SU	YOUTH	FEMALE PART of IDUs
1	18th Street	$122,901.00	F	DPH-CBO				$122,901					$14,748	$39,320		$4,916	$63,909	$61,451	$61,451		
2	18th Street	$75,000.00	S	DPH-CBO				$75,000					$9,000	$24,000		$3,000	$39,000	$18,750	$18,750	$37,500	
3	18th Street	$29,596.00	C	DPH-CBO		$29,596							$888	$1,480	$888	$2,960	$23,381	$11,838	$11,838	$5,919	
4	18th Street	$29,999.00	C	DPH-CBO								$29,999									
5	18th Street	$29,750.00	C	DPH-CBO			$29,750						$863	$1,438	$863	$2,875	$22,713	$11,500	$11,500	$5,750	
6	18th Street	$25,254.00	C	DPH-CBO			$25,254						$5,303	$6,818	$758	$758	$11,617	$10,102	$10,102	$5,051	
7	AIAI	$29,016.00	C	Non-DPH	$29,016											$29,016			$29,016		
8	AIAI	$14,334.00	C	DPH-CBO	$14,334								$14,047	$72	$72	$72	$72	$7,167		$7,167	
9	AIAI	$14,334.00	C	DPH-CBO	$14,334											$14,334		$3,584	$6,450	$1,433	$2,867
10	Asian AIDS Project	$154,105.00	F	Non-DPH	$154,105								$385	$539	$153,180			$116,503	$37,602		
11	Asian AIDS Project	$112,500.00	S	Non-DPH	$56,250	$56,250							$281	$394	$111,825			$112,500			
12	Asian AIDS Project	$72,413.00	F	DPH-CBO	$72,413								$181	$253	$71,979			$72,413			
13	BVHPF	$116,750.00	F	DPH-CBO	$116,750								$62,695	$14,127	$1,518	$817	$37,594	$1,985	$99,821	$5,020	$9,924
14	CAITC	$212,000.00	S	Non-DPH							$212,000										
15	CAITC	$64,952.00	F	DPH-CBO		$64,952							$64,952						$25,981	$19,486	$19,486
16	CAL-PEP	$161,837.00	C	DPH-CBO	$161,837								$69,426	$44,343	$2,268	$486	$45,314		$113,296	$19,420	$29,131
17	CCHospHouse	$51,500.00	C	DPH-CBO	$25,750			$25,750					$10,300	$10,540	$1,030	$1,545	$20,065			$51,500	
18	Center for Health Train	$30,000.00	S	Non-DPH							$30,000										
19	CSAS	$452,808.00	F	DPH-CBO								$452,808	$153,955	$239,988	$13,584		$45,281		$271,685		$181,123
20	CUAV	$10,868.00	C	DPH-CBO		$10,868							$1,608	$1,848	$5,923	$250	$1,239			$10,868	
21	CTLAB	$181,980.00	F	DPH-Other						$181,980											
22	CtrSEAsn Refugees	$277,517.00	F	Non-DPH			$5,273	$251,706	$3,330		$17,206		$69,379		$138,759		$69,379	$55,503	$27,752	$83,255	$111,007
23	Family Health	$140,121.00	F	DPH-Other						$140,121			$33,629	$21,859	$56,469	$841	$27,324	$1,401	$16,813	$113,078	$10,229
24	Filipino Task Force	$40,000.00	F	DPH-CBO	$40,000										$40,000			$20,000	$2,000	$16,000	$2,000
25	Forensic AIDS Project	$359,890.00	F	DPH-CBO						$359,890			$118,264	$81,355		$11,516	$150,794	$129,681	$199,739	$33,470	
26	GCHP	$130,625.00	C	DPH-CBO		$130,625									$130,625			$130,625			
27	GCHP	$60,000.00	F	DPH-CBO		$60,000									$60,000			$30,000	$30,000		
28	Glide AIDS Project	$62,007.00	F/C	DPH-CBO				$62,007.00					$36,770	$9,611	$2,790		$12,835	$23,501	$27,293	$4,961	$6,263
29	Glide AIDS Project	$56,312.00	F/C	DPH-CBO	$56,312.00								$33,393	$8,728	$2,534		$11,657	$21,342	$24,777	$4,505	$5,688
30	HAFCI	$93,771.00	F	DPH-CBO								$93,771									
31	Hispanic HQ	$150,000.00	C	DPH-CBO					$150,000					$150,000				$150,000			
32	Hispanic HQ	$73,000.00	S	DPH-CBO					$73,000					$73,000				$73,000			
33	Hispanic HQ	$62,700.00	C	DPH-CBO	$62,700									$62,700					$31,350	$15,675	$15,675
34	HIV PrE:SFCC-CTS	$747,472.00	F	DPH-Other						$747,472			$171,171	$159,959	$54,565	$9,970	$352,807	$295,999	$96,424	$278,807	$76,242

(1) Note: Fed Funds based on 1/93-12/93, State Funds based on 7/92-6/93 while Target Group Data based on 7/92-6/93; (5) Target Groups may overlap

HIV Prevention in San Francisco (Based on 92/93)

January 18, 1994

#	Program Name	Amount (1)	S(2)	Type (3)	TYPE OF INTERVENTION (4)								TARGET ETHNIC GROUP					TARGET RISK GROUP (5)			
					CLI	HERR	PCM	SO	PI	C/T	TRAINING	ADMIN/ R&E	AFRICAN AM	LATINO	ASIAN/PI	NATIVE AM	CAUC	GAY/BI	IDU/SU	YOUTH	FEMALE PART of IDU
35	HIV P+E:SFGH	$253,966.00	F	DPH-Other						$253,966			$94,475	$45,206	$10,921	$2,032	$101,332	$83,555	$129,777	$40,635	
36	IFR	$241,141.00	F	Non-DPH		$241,141								$241,141				$241,141			
37	IFR	$21,915.00	F	DPH-CBO		$21,915								$21,915							$21,915
38	Iris Center	$246,000.00	F	Non-DPH	$246,000								$147,600	$24,600			$73,800		$98,400		$147,600
39	Iris Center	$92,293.00	S	DPH-CBO	$92,293								$55,376	$9,229			$27,688		$36,917		$55,376
40	JCYC	$234,957.00	F	Non-DPH			$234,957								$234,957			$54,040		$157,421	$23,496
41	JCYC	$124,601.00	C	DPH-CBO		$124,601							$3,987	$9,220	$104,914	$1,246	$5,233	$28,658		$83,493	$12,460
42	JCYC	$40,587.00	F	DPH-CBO		$40,587									$40,587			$9,335		$27,193	$4,059
43	Lyon-Martin	$70,000.00	A	Non-DPH				$35,000			$35,000		$700	$3,570	$5,740	$700	$59,290	$56,000			$14,000
44	LYRIC	$75,000.00	S	DPH-CBO		$75,000							$11,250	$16,500	$12,500		$33,750	$75,000			
45	NTFA-W/Color Court	$267,943.00	F	Non-DPH	$267,943								$132,454	$34,553	$5,759	$9,638	$106,539	$267,943			
46	NTFAP	$30,000.00	C	DPH-CBO					$30,000				$30,000					$30,000			
47	Operation Concern	$65,852.00	C	DPH-CBO		$32,926	$32,926						$2,632	$2,239	$1,317	$329	$59,135	$65,852			
48	PIRIEDA Project	$1,278,327.00	F	Non-DPH				$1,278,327					$766,996	$255,665	$31,958	$31,958	$191,749		$319,582		$958,745
49	Planned Prnthd	$44,597.00	C	DPH-CBO		$44,597							$37,774	$1,828	$1,828	$446	$2,720		$22,299		$22,299
50	Polaris	$128,481.00	C	DPH-CBO							$128,481										
51	RAP	$70,000.00	S	Non-DPH				$70,000					$16,870	$44,660	$5,110	$630	$2,730	$70,000			
52	RAP	$38,309.00	S	Non-DPH				$38,309						$38,309						$38,309	
53	SFAF	N/A	S	Non-DPH									N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
54	SFAF	$249,583.00	F	Non-DPH			$249,583						N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
55	SFAF	$176,588.00	C	DPH-CBO		$176,588							$176,588					$176,588			
56	SFAF	$162,375.00	C	DPH-CBO	$162,375								N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
57	SFAF	$128,478.00	C	DPH-CBO					$128,478				N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
58	SFAF	$91,156.00	C	DPH-CBO	$91,156								N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
59	SFAF	$43,346.00	C	DPH-CBO					$43,346				N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
60	SFAF/CAL-PEP	$52,250.00	C	DPH-CBO	$52,250								$39,188				$13,063	$52,250			
61	SFAF/NTFAP	$124,355.00	C	DPH-CBO	$124,355								$124,355					$124,355			
62	SFAF/Prev Point	$137,971.00	C	DPH-AO	$137,971								$33,113	$16,557	$2,759	$2,759	$82,783		$137,971		
63	SFDPH-AO:AESOP	$376,669.00	F	DPH-AO								$376,669									
64	SFDPH-AO:PartRef	$65,616.00	F	DPH-AO						$65,616			$16,404	$16,404			$32,808	$22,966	$22,966	$6,562	$13,123
65	SFDPH-AO:YPEP	$180,000.00	S	DPH-AO		$180,000							$120,600	$18,000	$18,000	$5,400	$18,000			$180,000	
66	Stop AIDS	$269,463.00	F	Non-DPH				$269,463					$53,893	$26,946	$13,473	$5,389	$169,762	$269,463			
67	Stop AIDS	$135,000.00	S	Non-DPH	$135,000								$10,665	$13,500	$10,530	$2,295	$98,010	$135,000			
68	TARC	$108,680.00	C	DPH-CBO				$54,340			$54,340		$24,562	$16,356	$1,087	$1,087	$11,248		$54,340		

(1) Note: Fed Funds based on 1/93-12/93, State Funds based on 7/92-6/93 while Target Group Data based on 7/92-6/93; (5) Target Groups may overlap

HIV Prevention in San Francisco (Based on 92/93)

January 18, 1994

#	Program Name	Amount (1)	S(2)	Type (3)	TYPE OF INTERVENTION (4) CLI	HERR	PCM	SO	PI	C/T	TRAINING	ADMIN/ R&E	TARGET ETHNIC GROUP AFRICAN AN	LATINO	ASIAN/PI	NATIVE AM	CAUC	TARGET RISK GROUP (5) GAY/BI	IDU/SU	YOUTH	FEMALE PART of IDU
69	UCSF/AHP	$679,025.00	F	DPH-CBO						$679,025			$40,742	$86,236	$48,211	$4,753	$499,083	$501,799	$42,778	$87,594	$46,853
70	UCSF/AHP	$239,305.00	C	DPH-CBO		$239,305							$11,965	$21,537	$4,786	$2,393	$198,623	$220,161	$19,144		
71	UCSF/UHS	$424,000.00	F	DPH-CBO						$424,000			$226,960	$67,840	$8,480	$8,480	$110,240		$424,000		
72	WEDGE	$288,716.00	F	DPH-Other		$288,716							$60,630	$68,405	$112,599	$2,021	$47,061			$288,716	
73	WNC	$214,000.00	S	Non-DPH				$107,000		$107,000			$160,500	$42,800			$10,700		$107,000		$107,000
74	YGC	$193,889.00	F	DPH-CBO		$193,889							$57,565	$26,175	$20,940	$10,664	$78,525	$7,756		$186,133	
GRAND TOTAL:		$11,927,746.00			$2,133,144	$2,011,556	$576,743	$2,389,805	$428,154	$2,959,070	$477,027	$952,247	$3,329,284	$2,127,754	$1,547,063	$173,576	$2,968,871	$3,867,706	$2,567,393	$1,814,911	$1,896,558
					18%	17%	5%	20%	4%	25%	4%	8%	33%	21%	15%	2%	29%	38%	25%	18%	19%

(2) FUNDING SOURCE
A = AmFAR/Private
C = City/General Fund
F = Federal/CDC
S = State

(3) TYPE OF SERVICE PROVIDER
DPH-AO = Dept of Public Health AIDS Office
DPH-CBO = Community Based Organization - Funding Received through DPH
DPH-Other = Received through DPH
Non-DPH = Funding Received Directly from Funding Source

(4) TYPE OF INTERVENTION
ADMIN/R&E = PROGRAM ADMINISTRATION; RESEARCH; PROGRAM EVALUATION
CLI = COMMUNITY LEVEL INTERVENTION
C/T = COUNSELING AND TESTING
HERR = HEALTH EDUCATION & RISK REDUCTION
PCM = PREVENTION CASE MANAGEMENT
SO = STREET OUTREACH
PI = PUBLIC INFORMATION
TRAINING = PROVIDER TRAINING

(1) Note: Fed Funds based on 1/93-12/93, State Funds based on 7/92-6/93 while Target Group Data based on 7/92-6/93; (5) Target Groups may overlap

Chapter 2:

Resource Inventory

Appendix B:

Summary of Agency Annual Reports Submitted to SFDPH AIDS Office for CDC Funded Programs

APPENDIX B

SUMMARY OF 1993 AGENCY ANNUAL REPORTS SUBMITTED TO SFDPH AIDS OFFICE FOR CDC-FUNDED PROGRAMS

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Name: 18th Street Services Street Outreach

Funding Period: 1993

Summary: This program was successful in reaching its goals for objectives 1, 2, 3, and 6. I was not successful in reaching its goals for objectives 4, 5, 7, 8 and 9.

Objective 1: From January 1993 through December 31, 1993, substance abuse counselors participated in training sessions on counseling, testing and HIV risk reduction topics. New staff received basic training and current staff received advanced training and networked with other providers in the field.

Evaluation Tools: Attendance at trainings, meetings and provision of in-services were documented by the Clinical Director and reported quarterly.

Conclusion: The goals for objective 1 were met.

Objective 2: From January 1, 1993 through December 31, 1993, 240 substance abuse clinic clients would receive, within two weeks of intake, an individual assessment of risk for HIV and would participate in on-going HIV risk reduction counseling sessions (either group or individual).

Evaluation Tools: The number of assessments conducted, the summary information from the assessments, and the referrals were recorded and reported quarterly.

Conclusion: The goals of objective 2 were met.

Objective 3: From January 1, 1993 through December 31, 1993, a client satisfaction questionnaire would be administered to 100 clients to determine their perceived treatment needs and record their evaluation of services received.

Evaluation Tools: Summary analysis of questionnaires were reported quarterly to CSAS and the AIDS office.

Conclusion: The goals of objective 3 were met.

Objective 4: It was projected that from January 1, 1993 through December 31, 1993, 30 sexual and/or needle-sharing partners of clients would be provided with risk reduction counseling, 15 of them would be provided with one-site HIV testing and counseling.

Evaluation Tools: The number of partners receiving services, HIV testing, counseling and referrals was recorded and reported quarterly.

Conclusion: The goals of objective 4 were not met. Agency stated that it would research barriers to this service.

Objective 5: From January 1, 1993 through December 31, 1993, 240 clients would be offered on-site HIV testing and counseling and 100 would participate in on-site testing and counseling.

Evaluation Tools: Demographic data forms and numbers of clients tested were submitted to the AIDS Office by the 18th of each month following testing. Numbers of appointments kept were recorded and submitted to the AIDS Office for inclusion in the quarterly progress report.

Conclusion: The goals of objective 5 were not met as only 60% of projected 100 received services. This was the first year that on-site testing was offered at 18th Street and it was judged a success by the staff even though the numerical objective was not reached.

Objective 6: From January 1, 1993 through December 31, 1993, 200 clients would participate in on-going groups in which HIV risk reduction education and training would take place.

Evaluation Tools: Number of clients in attendance was recorded and reported quarterly.

Conclusion: The goals for objective 6 were met.

Objective 7: From January 1, 1993 through December 31, 1993, 50 high risk clients would receive prevention case management services.

Evaluation Tools: Numbers of clients so identified was recorded and the number of PCM components in client population was recorded and reported quarterly.

Conclusion: The goals of objective 7 were not met. 18th Street Services considers all of its clients to be high risk and risk reduction strategies are integrated into every client's recovery program. Therefore, it was hard to work with the wording of this particular objective. Some clients, however, were identified as having a pattern of failures, and together with newly identify seropositives, were targeted for additional prevention case management.

Objective 8: From January 1, 1993 through December 31, 1993, 50 seropositive clients would be referred to qualified sites for primary care.

Evaluation Tools: Number of clients so referred were recorded and reported quarterly.

Conclusion: The goals for objective 8 were not met. To date only seven of the projected 50 utilized this service. However 100% of the new identified seropositive individuals were referred to SFGH for primary care.

Objective 9: From January 1, 1993 through December 31, 1993, partner notification procedures would be established and communicated to clinical staff; 100 clients would be informed of partner notification options.

Evaluation Tools: A copy of the procedures was provided to CSAS and AIDS Office along with the number of participating clients.

Conclusion: The goals for objective 9 were not met. The agency stated that partner notification and partner counseling and testing had turned out to be more difficult than originally assumed and the agency

targeted this as an area for technical assistance and restructuring in 1994.

Name: **Asian AIDS Project**

Funding Period: 1993

Summary: As the report provided did not include the first, third or fourth quarterly progress reports it is only possible to ascertain the success of the second quarter. Unless, the goals for the year were exceeded in the second quarter it was not possible to assess success for that objective. Consequently, this program was up-to-date in its target goals for objectives 1, 2 and 3. Additional information is needed for assessment of objectives 4 and 5. However, given available data it appears as though objective 6 did not achieve its goal.

Objective 1: By December 31, 1993 the health educator would provide educational presentations to women, youth and members of the Chinese, Southeast Asian and Pacific Islander communities, in order to increase their knowledge and change their attitude about HIV transmission/prevention. Two hundred APIs would be served per quarter or a total of eight hundred for the year.

Evaluation Tools: Pre- and post-tests were administered during each presentation and workshop; the post-tests showed an increase in the knowledge around HIV transmission and prevention. In addition, staff requested a Speaker's Bureau Evaluation and feedback from client groups.

Conclusion: The goals for objective 1 were up-to-date. The agency had delivered 77% of its contract at the end of the second quarter.

Objective 2: By December 31, 1993, the Health Educator would participate in at least 4 community events or forums in San Francisco to provide HIV/AIDS information to 500 women, 150 youth and 350 members of the Chinese, Southeast Asian and Pacific Islander communities, in order to increase their knowledge of and change their attitude about HIV transmission/prevention. Two hundred fifty

APIs would be reached each quarter, or a total of one thousand for the year.

Evaluation Tools: Questionnaires, surveys and safe sex quizzes were used to gauge contacts' knowledge of HIV and AIDS. In addition, AAP's multilingual phone line provided HIV/AIDS information to a total of 58 callers during the second quarter. Of these callers, 28 were referred to other service providers, including anonymous testing sites.

Conclusion: The goals for objective 2 were met. The agency had delivered 122% of its contract units by the end of the second quarter.

Objective 3: By December 31, 1993, the Health Educator would provide various radio and TV stations, magazine and newspaper publications in San Francisco with information and articles, in order to educate about the impact of HIV/AIDS on API communities. Twenty-five contacts per quarter would be provided, or a total of one hundred contacts for the year, of which 10 contacts would result in an article or feature story and/or an appearance on radio or TV.

Evaluation Tools: Prevention services documents were used to log these activities. In addition, hard copies of articles and releases were kept on file.

Conclusion: The goals for objective 3 were met. By the end of the second quarter the agency had fulfilled 119% of the contract.

Objective 4: By December 31, 1993 the Health Educator would train volunteers from the various API communities in San Francisco to provide HIV/AIDS information to their communities. Six volunteers per quarter would be trained, or a total of twenty-four for the year.

Evaluation Tools: Volunteer application forms and activity logs were used. Pre- and post-tests, including a training evaluation were administered.

Conclusion: Unable to determine year end conclusion from data provided for goals of objective 4. By the end of the second quarter 46% of the total contract units had been completed. A report at the end of the funding period assessing the success of this objective would need to be acquired.

Objective 5: By December 31, 1993, the Health Educator would develop a safe sex kit and handbill targeted towards gay/bisexual API men, and a video of AAP's play targeting API youth. These materials were used to initiate and maintain changes in risk behavior among the client populations. 2,000 safe sex kits and 1,000 handbills were distributed to gay/bisexual men.

Evaluation Tools: A list of potential vendors, graphic designers, and printers was compiled to work on the educational materials. AAP staff conducted preliminary meetings with some vendors to discuss prices and production costs. AAP utilized focus groups to develop themes for educational materials. A distribution log was kept on the number of materials distributed during the period of the contract.

Conclusion: Unable to determine year end conclusion from data provided for goals of objective 5. A report documenting the end of the funding period assessing the success of this objective would need to be acquired.

Objective 6: By December 31, 1993, AAP Health Educator would provide prevention case management service to at least 20 high-risk API clients in San Francisco in order to help them assess HIV prevention services and to help them initiate and maintain changes in risk behavior. A caseload of ten clients per quarter would be served or a total of 20 clients for the year.

Evaluation Tools: AAP developed a standardized information system to provide tracking and documentation of individual clients. AAP consulted with other service providers to determine what was in

place.AAP developed a system of documentation through logs and service referrals to outside health and social service providers.A client survey was developed and interviews were conducted to assess program implementation and overall effectiveness of the program.These activities were reported in quarterly reports to the AIDS Office.

Conclusion: During the second quarter Health Educator was able to provide services to four individuals. This fell below the contract amount on a quarterly basis, which was ten. However, as no assessment of the third or fourth quarters is included in this report, it is not possible to ascertain whether the goals were met for the entire contract period. The logical assumption would be that the contract goals were not met.

Name: **Asian American Communities Against AIDS (AACAA) Japanese Community Youth Council**

Funding Period: 1993

Summary: This project achieved the goals of objectives 5, 6 and 7. It did not achieve the goals of objectives 1, 3 and 4. There was no information in this report as to the achievement of the goals for objective 2.

Note: This annual report was very inconsistent with figures and conclusions, especially as these figures related to percentages. Also there was a fire in the JCYC offices that destroyed fourth quarter reports, thereby hampering accurate reporting.

Objective 1: By November 30, 1993, 42 contacts would have been made to the Chinese, Japanese, Korean, Filipino and Southeast Asian media by the project director, project coordinators, health educators/peer counselors and volunteer peer educators for shaping community attitudes towards AIDS awareness, sensitivity, and risk reduction and to inform the general public about their programs, activities and events. 50% of the contacts would be made with the monolingual or non-English proficient population.

Evaluation tools: Verification of press releases were made with copies of press releases, including distribution lists and random sampling of published articles. Verification of telephone and face-to-face interviews were made through documentation logs. TV and radio interviews were documented with video/audio copies whenever possible and through confirmed observations. Feedback from media personnel and the public was encouraged and documented to determine success, barriers or problems.

Conclusion: The 42 contacts were to be completed over the period of two quarters with each quarter acquiring 21 units of contact. Only 40 contacts were made,

consequently, this project accomplished 95% of its goal for objective 1. They had excellent success reaching the Chinese and Japanese communities but limited success in reaching the Filipino, Southeast Asian and Korean communities. Their annual report is a bit confusing on the quantitative documentation. Although the objective was to acquire 42 units, 21 each quarter, they state in their addendum that 40 units equals 222%.

Objective 2: By November 30, 1993, the project director, project coordinators and health educators/peer counselors would contact 57 community agencies, community leaders, other AIDS service providers and influential individuals to plan future strategies for prevention services and cooperative agreements and involvement of other service providers in the implementation of future programs and to seek new resources for service delivery without duplication. The outcome would be a plan of action to address HIV related service needs in the Asian and Pacific Islander communities.

Evaluation Tools: Verification was made through telephone, interview and meeting logs. The project director reviewed documentation of service units completed on a monthly basis to determine the effectiveness of this activity based upon the success of the implementation of the action plan developed to address HIV related service needs in the Asian and Pacific Islander communities.

Conclusion: The annual report provided no information as to whether this objective was reached. A barrier to obtaining this information was the flooding of the JCYC offices in early January, 1994. Consequently, a progress report was promised in the first quarterly report for 1994.

Objective 3: Chinese health educator/counselor and trained volunteers/interns would conduct street outreach to engage 40 at risk youth, ages 12-21 to build a

trusting relationship to assess their high risk behavior, encourage safer sex practices and reduce drug/substance use related behaviors, and to recruit clients for confidential counseling or group educational workshops.

Evaluation Tools: Verification of contacts was made through documentation logs and field notes. Impact was measured by assessing the number of contacts versus the number of intakes and successful referrals to counseling, workshops or other services.

Conclusion: This objective was dropped due to a reduction in the grant to the agency.

Objective 4: By December 31, 1993, all staff and volunteers/interns would provide information and referrals to 134 individuals to the Chinese, Japanese, Korean, Filipino and Southeast Asian population and answer specific questions about HIV prevention and transmission, testing, counseling, and other related health issues, services and resources.

Evaluation Tools: Verification was made by referral logs, as well as documentation of community events. The project director and staff reviewed monthly, the type of inquiries being received to determine the effectiveness of the responses.

Conclusion: Again the documentation of this report is confusing. The flooding of the JCYC offices contributed to the lack of progress report material. The agency stated that it completed 200% of its goals in the first quarter. However, when a tally is made of the actual contacts made, that number equals 114, which is 85% of the projected goal of 134.

Objective 5: By December 31, 1993, the Korean consultants and Filipino project coordinator would revise/reprint and distribute 1,500 brochures/pamphlets to participants of their activities and to the general

Korean and Filipino population for the purpose of reaching the traditionally hard-to-reach members of their respective communities.
Due to the removal of the Korean community from the consortium the objective was changed in the third quarter. The number of brochures/pamphlets was changed from 1,500 to 500 for distribution in the Filipino community.

Evaluation Tools: Verification was made by distribution logs. Verbal written comments were encouraged from distribution outlets and the general public regarding positive or negative feedback and was maintained on file. Follow-up at distribution outlets was made to determine the effectiveness of continued use of these outlets.

Conclusion: The goals for this objective were met at the level of 100%. However, in the annual report the agency states that the goals were met at the level of 149%.

Objective 6: By December 31, 1993, the Filipino project coordinator, Chinese health educator/counselor and Japanese health educator/counselor would provide 26 hours of counseling to a minimum of 16 clients in a confidential environment to address personal issues, which are not openly discussed in group settings, provide information on risk reduction techniques, assess client needs for other services, and make necessary referrals to other service providers with follow-ups.

Evaluation Tools: Intake forms for each client was completed to include client demographics and the location, date, length and nature of counseling activities. Referrals to other services was also noted and followed-up with both the client and other service providers. Follow-ups and subsequent counseling activities were matched to the original document to assure continuity of services and referrals and to avoid recording of duplicated clients.

Conclusion: This agency was very successful in achieving the goals of objective 6. They counseled 24 clients with

a total of 71.5 hours of counseling/referrals. This is 275% of the hours projected in the original objective. Again, however, the annual report states that they reached 105% of their projected goal.

Objective 7: By December 31, 1993, the Filipino and Southeast Asian project coordinators, Japanese and Chinese health educators, and volunteer peer educators were to conduct approximately 12 educational workshops ranging from 1 hour to 2.5 hours for a minimum of 272 participants for a total of 321 service units and for the purpose of educating them about their possible risks for HIV infection and other diseases. At least 70% of participants were to attain a score of at least 75% on overall knowledge of HIV and correctly identify three methods of HIV transmission and three methods of HIV prevention on post-tests. Furthermore, at least 40% of post-tested participants were to demonstrate an intent to engage in safer behavior and report feeling more comfortable in negotiating safer sex practices.

Evaluation Tools: Logs were maintained to recover the number of participants, time and place of workshops, ethnicity, sex, sexual orientation, age group, place of birth, length in U.S. for immigrant/refugee and a brief description of the workshops.

Post-test evaluation forms were collected from at least 190 of the 272 participants. Preliminary evaluations of the workshops were performed by the project coordinators and health educators. Workshops were also evaluated by participants on a scale of 1 to 5 from poor to excellent as well as other comments. The project director and staff further evaluated post-test results monthly to determine which questions were frequently missed and why.

Conclusion: There were 19 workshops held in the first quarter which is 158% of projected 12 workshops. 348 participants engaged in these workshops which is 127% of projected 272 participants. 626.5 hours of participation was accomplished which is 230% of projected 321 participant hours. The agency met

and surpassed its goals for objective 7. Again, however, there was a discrepancy between the numbers reported and the percentages given in the evaluative section of report.

Name: **Bayview Hunter's Point Foundation**

Funding Period: 1993

Summary: Early in report this agency notes barriers to completing its objectives. The program was put on probation and received regular technical assistance. Also the agency consistently noted that a funding cut of 50% had severely hampered their ability to provide services. This agency met its goals in objectives 3, 5, 8, and 9. Ninety-seven percent of its goal was achieved in objective 1. This agency did not meet the goals in objectives 2, 4, 6, and 7.

Objective 1: By December 31, 1993, 500 clients at Bayview Hunter's Point would receive individual HIV risk assessment and HIV pre-test counseling. 125 clients per quarter were expected to participate in this objective. These were clients who were enrolled in substance abuse services at the foundation.

Evaluation Tools: Client demographic and referral information was analyzed and reported on a quarterly basis. The evaluation process analyzed; the number of clients accessing same day testing; the numbers of clients returning for post-tests counseling and the results; and the number of clients who followed through with intervention plans.

Conclusion: The agency did not meet its goals for objective 1. However, the final assessment states that they met 97% of the contract goals.

Objective 2: By December 31, 1993, 175 clients would have taken an HIV antibody test.

Evaluation Tools: Demographic information on clients testing was collected, analyzed and reported quarterly. The outreach workers recorded the number of people referred to testing on demand. The program recorded the numbers tested versus the numbers referred. The number of no-shows for referred clients compared to methadone clients was evaluated.

Conclusion: The goals for objective 2 were not met. Barriers identified included: resignation of program director; funding cuts; and closure of methadone detox program. The agency changed the hours to make the program more accessible to the community.

Objective 3: By December 31, 1993, 20 sexual/needle sharing partners would also receive an individual HIV risk assessment, pre- and post-test counseling and an antibody test.

Evaluation Tools: Demographic information on partners was collected, analyzed and reported quarterly, including information on participation in testing, post-test counseling, early intervention referrals and risk reduction support groups. The required demographic data form was submitted monthly to the AIDS Office.

Conclusion: The goals of objective 3 were met.

Objective 4: By December 31, 1993, 130 clients would have taken the HIV antibody test and would return for post-test counseling.

Evaluation Tools: Demographic information on client testing was collected, analyzed and reported quarter. Referral information was entered onto the required demographic data form and submitted to the AIDS Office each month.

Conclusion: The goals of objective 4 were not met. The agency only fulfilled 51% of the contracted amount. Actual client return rate was 60%, an improvement from 1992, but still below goal of 75%. The agency states that the program was restructured, based on the assumption that better integration into the substance abuse components would simplify and improve follow-up with post-test no shows.

Objective 5: Two on-going weekly groups would be provided to an average of eight individuals per group.

Evaluation Tools: The number of participants in each group was recorded and reported quarterly. A follow-up survey was given to IDUs to measure change in needle sharing behavior. A follow-up survey was given to all clients to measure risk reducing sexual behavior.

Conclusion: Contract goals for objective 5 were met.

Objective 6: By December 31, 1993, HIV counseling and testing staff would participate in two trainings provided by SFDPH each quarter. In addition, staff would represent the program at the quarterly AIDS Office counseling and testing meetings and the monthly CSAS HIV and Substance Abuse Task Force meetings.

Evaluation Tools: The number of staff members attending trainings and the number of staff providing in-services was documented and reported on a quarterly basis.

Conclusion: The goals for objective 6 were not met. Agency stated that barriers included funding cuts and consequent cuts in staff numbers.

Objective 7: By December 31, 1993, 130 clients would return for post-test counseling, both positive and negative, and would be provided with prevention counseling.

Evaluation Tools: Demographic information on clients was collected, analyzed and reported quarterly, including information on participation in one-to-one counseling, risk reduction support groups, and early intervention referrals. The required demographic data form was submitted monthly to the AIDS Office.

Conclusion: The goals for objective 7 were not met. The agency stated that the numbers for this objective were below projection due to the below projected rate of HIV testing.

Objective 8: By December 31, 1993 all clients who tested positive would return for post-test counseling and be referred for CD4 testing, monitoring and related medical care as indicated by the results of the tests.

Evaluation Tools: Demographic information on client referrals and follow through was collected, analyzed and reported quarterly. Follow-up contact was initiated with clients who did not keep their medical appointments.

Conclusion: The goals for objective 8 were met.

Objective 9: By December 31, 1993, all clients who tested positive would receive assistance notifying their partners of their sero-status. Partners so notified would be offered complete HIV testing, counseling and referral services at the clinic, or if they preferred, a referral program.

Note: No evaluation tools were discussed in this report for Objective 9.

Conclusion: The goals for objective 9 were met.

Name: **Bayview Hunter's Point Foundation AIDS Prevention Outreach**

Funding Period: 1993

Summary: This agency met its goals for objectives 1, 2 and 4. It did not meet its goals for objectives 3 and 5.

Objective 1: A minimum of 1,000 out-of-treatment injection drug users would receive AIDS/STD prevention messages and materials, and referral to primary health care services via street outreach by December 31, 1993.

Evaluation Tools: Process evaluation was used to record number of contacts made, locations/geographic area, gender, ethnicity, number of education materials distributed, and number of referrals made. To the extent possible, clients were asked to demonstrate their skills around needle hygiene and knowledge of needle exchange. Referrals made for primary health care services were tracked through agency representatives and through verbal feedback from clients.

Conclusion: The goals for this objective were met and surpassed. 1,347 drug users received prevention messages and materials, which is 135% of the projected 1,000.

Objective 2: By December 31, 1993, a minimum of 2,000 at-risk men and women would receive AIDS/STD prevention and risk reduction information and, as a result, would learn where to go for free antibody testing, STD screening, risk reduction counseling or substance abuse treatment and/or counseling (including the Bayview Hunter's Point program).

Evaluation Tools: Process evaluation was used to record the number of contacts made, location or geographic area served, material distributed, and number and type of referral made. An oral post-test was administered to the extent possible to determine the clients' level of knowledge in regard to where to go in San Francisco for free HIV antibody testing,

STD screening, risk reduction counseling or substance abuse counseling and treatment.

Conclusion: This agency met and surpassed the goals of objective 2. 2,950 at-risk men and women received information, which is 147% of the projected 2,000.

Objective 3: By December 31, 1993, a minimum of 1,000 high risk youth would receive AIDS/STD prevention messages, informational material and referral information for appropriate needed services.

Evaluation Tools: Process evaluation and some outcome evaluation was conducted to track number of contacts made with adolescents, demographic information for clients served, number of referrals made for STD/AIDS screening and/or treatment, or risk reduction counseling. Attempts were made to get adolescents to demonstrate their skill level in regard to proper usage of condoms.

Conclusion: This agency did not meet the goals for objective 3. Only 504 high risk youth received information, which is 50% of the projected 1,000. The main barrier cited was the resignation of the youth outreach worker in the first quarter.

Objective 4: A minimum of 1,000 African-American women would receive AIDS prevention messages and materials and referrals to drug treatment specific to women via street outreach by December 31, 1991.

Evaluation Tools: One third of these individuals were given a verbal post-intervention knowledge survey which was documented on paper by the outreach worker.

Conclusion: This agency met and surpassed its goals for objective 4. 1,129 women received materials/referrals, which is 113% of the projected 1,000.

Objective 5: 1,170 post-intervention KABB surveys would be administered to IDUs, youth at risk and women (by 4 outreach workers) to evaluate changes in

knowledge, behaviors and attitudes about HIV issues.

Evaluation Tools: Post-assessment KABB surveys were tabulated by the outreach worker. Raw data was input by the data manager and interpreted by the program manager AIDS facilitator, media director and AIDS/HIV consultant. Data gained from the post-intervention surveys were used to assess materials being used and information being disseminated.

Conclusion: This agency did not meet its goals for objective 5. Only 230 surveys were available to be analyzed, which is 19% of the projected 1,170.

Name: **California AIDS Intervention Training Center**

Funding Period: 1993

Summary: This agency far surpassed its goals for objectives 1, 2 and 3. There were no other objectives in this funding period.

Objective 1: By December 31, 1993, AACEP staff would conduct 6 group presentations for HIV/STD prevention education involving 120 African Americans in the Western Addition, including 30 women, 30 sexually active teenagers, 30 substance abusing youth and adults and 30 men with multiple sexual partners. 25% of total clients would be youth ages 13-24. 90 (75% of 120) clients attending group presentations would improve their knowledge of HIV/STD transmission and the skills and behavior changes necessary to prevent transmission by 25% as measured by pre- and post-tests developed by AACEP staff.

Evaluation Tools: Evaluation instruments were developed by AACEP staff during the start-up period. These evaluation instruments included attendance records/participant demographics, pre and post-questionnaires, staff records of community feedback, educational materials/resources distributed, and evaluation forms filled out by participants. The target population clients were provided feedback directly during presentations, workshops and counseling sessions which was recorded on interview/questionnaire forms or pre- and post-tests. The clients were given the opportunity to fill out written evaluation forms at the end of each community presentation or peer workshop.

Conclusion: This agency met and surpassed its goals for objective 1.

Objective 2: By December 31, 1993, AACEP staff would conduct 90 private counseling sessions with 48 individuals (singly or in dyads), including 12 women, 12

sexually active teenagers, 12 substance abusing youth or adults and 12 men with multiple sexual partners. 24% of total clients would be youth ages 13-24. 24 (50% of 48) clients would attend 2 or more counseling sessions and their changes in knowledge, attitude and risk behaviors over time would be tracked by instruments developed for this purpose by AACEP staff.

Evaluation Tools: Evaluation instruments were developed by AACEP staff during the start-up period. These evaluation instruments included attendance records. Also, educational materials/resources were distributed.

Conclusion: This agency met and surpassed its goals for objective 2.

Objective 3: By December 31, 1993, AACEP staff would conduct 10 small group participatory workshops to build peer support for HIV/STD preventive behavior change with 48 individuals, including 12 women, 12 sexually active teenagers, 12 substance abusing youth or adults, and 12 men with multiple sexual partners. 25% of total clients would be youth between the ages of 13-24. 16 (33% of 48) of the clients would attend 2 or more peer support workshops and their changes in knowledge, attitude and risk behaviors over time would be tracked by instruments developed for this purpose by AACEP.

Evaluation Tools: Evaluation instruments were developed by AACEP staff during the start-up period. These evaluation instruments included attendance records, participant risk behavior self-assessments, and confidential client record forms that included demographic and follow-up information. Education materials were distributed.

Conclusion: This agency far surpassed its goals for objective 3.

Name:	**Coalition for Immigrant and Refugee Rights and Services**
Funding Period:	1993
Summary:	This agency met its goals for objectives 1 and 2. It did not meet its goals for objectives 3 and 4.
Objective 1:	By December 31, 1993, 13 immigrant Latino gay and bisexual men, recruited as promotors, would participate in 35 hours of HIV/STD prevention training and would demonstrate a gain of at least 25% in knowledge about HIV as measured by pre- and post-intervention assessments.
Evaluation Tools:	An evaluation of the process was conducted by the Advisory Committee. Methods utilized to evaluate the process included activity logs submitted by program staff, outreach reports submitted by promotors, monthly and quarterly reports and statement of deliverables and invoices submitted to the AIDS Office. An evaluation of the outcome was conducted by the Program Director and the Project Assistant. During this period two risk assessments were conducted for each adult promotor (one for each youth promotor). The risk assessments allowed program staff to measure knowledge, attitudes and behavior of promotors and any change thereof.
Conclusion:	The goals of objective 1 were met.
Objective 2:	By December, 1993, 250 immigrant gay and bisexual Latino men would have been contacted by the promotors, received basic HIV prevention education and been assessed in terms of their personal risk for HIV. 150 of these individuals would have agreed to participate in the long term risk reduction progra
Evaluation Tools:	An evaluation of the process was conducted by the Advisory Committee. Methods utilized to evaluate the process included activity logs submitted by

program staff, outreach reports submitted by promotors, monthly quarterly reports and a statement of deliverables and invoices submitted to the AIDS Office. Two risk assessments were conducted for each adult promotor (one for each youth promotor). The risk assessments allowed program staff to measure knowledge, attitudes and behavior of promotors and any change thereof.

Conclusion: The goals of objective 2 were met.

Objective 3: By December 31, 1993, 15 unduplicated immigrant Latino gay and bisexual men would participate in 8 hours of risk reduction workshops. A minimum of 11 participants would demonstrate a 50% increase in knowledge about HIV as measured by pre- and post-intervention assessments.

Evaluation Tools: Methods utilized to evaluate the process included activity logs submitted by program staff, workshop attendance records, monthly and quarterly reports and a statement of deliverables and invoice submitted to the AIDS Office.

Conclusion: As of December 31, 1993, only 111 workshop hours for 15 adult clients had been completed and no pre- and post-tests had been tabulated. The agency partially met the goals of objective 3.

Objective 4: By December 31, 1993, 15 unduplicated immigrant Latino gay and bisexual men would participate in *Friendship Circles*. The circles would occur twice a month and last two hours. 20% of non-promotor participants were expected to increase their knowledge of risk behaviors for HIV by 25% as demonstrated by the pre- and post-test intervention risk assessments.

Evaluation Tools: Methods utilized to evaluate the process included activity logs submitted by program staff, workshop attendance records, monthly and quarterly reports and a statement of deliverables and invoices submitted to the AIDS Office.

Conclusion: This agency did not reach the goals for objective 4.

The leadership training began one month behind schedule, pushing back the start date of other activities, including the *Friendship Circles*. In addition, not all promotors were able to continue in the program for health and other reasons. They were therefore, not able to achieve projected attendance levels until near the end of the funding cycle.

Name: **Community Substance Abuse Services Coordination HIV Prevention in Drug Users**

Funding Period: 1993

Summary: This is essentially a technical assistance provider/monitoring organization. All of its objectives were met in 1993.

Note: No evaluation tools were discussed in the annual report. Of interest, the annual reports for Westside Methadone Treatment Program and Westside Inner-City Outpatient Services were also contained in this report.

Objective 1: By April 1, 1993 CSAS would work with the AIDS Office to negotiate contracts with the named agencies to achieve the objectives approved by the AIDS Office. Named agencies are Westside, 18th Street Services, Haight Ashbury, Bayview-Hunter's Point and AIDS Health Project.

Conclusion: Contracts with the named agencies were negotiated, approved by the AIDS Office and executed.

Objective 2: CSAS would provide technical assistance and regular program monitoring to assure adequate progress throughout the year and adherence to program design and policies required by the contracts.

2a. By July 1, 1993, a site-monitoring visit and report was to be completed for each contractor.

Conclusion: A site monitoring report was completed for each contractor and forwarded to the AIDS Office.

2b: CSAS would offer one technical assistance meeting each quarter on evaluation and reporting, and prevention case management topics such as program management, operations and meeting objectives.

Conclusion: At least four technical assistance meetings were held with each contractor during the year. The agencies included Westside, 18th Street Services, Haight Ashbury, Bayview-Hunter's Point and AIDS Health Project.

Objective 3: With assistance from the AIDS Office, CSAS would engage in direct evaluation of client outcomes and client satisfaction with services.

Conclusion: Each program developed a procedure for client outcomes and client satisfaction surveys. The implementation timetable for assemblage of client satisfaction surveys and analysis of resultant data was scheduled for the first and second quarters of 1994.

Objective 4: By April 1, 1993, CSAS would assure that each contractor had specific written policies in effect.

4a. A written plan to contact post-test no-shows.

Conclusion: Each program has a policy in place. Bayview-Hunter's Point is the only agency which has continued to show a high rate of no-shows and the AIDS Office and CSAS are in the process of extended technical assistance to deal with this problem

4b: A written plan to achieve a testing rate of 50% or more within the agency's base clientele.

Conclusion: Westside and 18th Street have achieved this level. Haight-Ashbury has improved the rate this year, but is still low and will target this problem for improvement during 1994. Bayview-Hunter's Point has made little improvement on this problem, is receiving technical assistance, and will remain on a probationary status.

4c: An up-dated client fee policy which generates revenue without creating a barrier to clients who need services.

Conclusion: All agencies have up-dated, written fee policies.

Objective 5: CSAS would monitor demographic reporting on a monthly basis and enforce compliance. The rate of program testing/referral of its base client population would be monitored, as well as the rate of return for post-test counseling.

Conclusion: Westside, Haight-Ashbury and AIDS Health Project maintained a good pace of output throughout the year. 18th Street Services' output was low all year, but improved slowly with repeated interventions. Bayview's output improved slightly, then fell. The contract was put on a probationary basis and technical assistance was provided with a remedial work plan negotiated for the first half of 1994.

Objective 6: CSAS would provide and facilitate networking, flow of information and client referral into and through substance abuse programs through monthly provider meetings ad hoc seminars and its weekly newsletter.

Conclusion: CSAS held monthly provider meetings, as well as monthly HIV and Substance Abuse meetings, and used a weekly newsletter to circulate announcements and information beyond the narrow circle of HIV Counseling programs.

Name: **Filipino Task Force on AIDS - HIV and AIDS Prevention Program for the General Filipino Community of San Francisco**

Funding Period: 1993

Summary: The agency met and surpassed its goals for objectives 1, 2, 3 and 4. The goals for objective 5 were not met as this objective was dropped during contract negotiations.

Objective 1: By December 31, 1993, this agency would have provided HIV/AIDS education activities to 350 unduplicated members of the Filipino community.

Evaluation Tools: Pre- and post-tests were administered to participants of the four interactive family workshops and the two community group meeting presentations. Results of the tests would indicate at least a 15% to 20% increase in knowledge of HIV and AIDS. Education and information was provided on a one-on-one basis during major community events, as well as drop-in or phone-in basis at FTFA, and was evaluated by means of the one-on-one interaction with the client.

Conclusion: This agency met and surpassed its goals for objective 1. 589 clients were provided educational activities and showed a marked increase in understanding. This number is 168% of the projected 350.

Objective 2: By December 31, 1993 this agency would have distributed 3,500 brochures and door handle tags containing HIV and risk-reduction information targeting the Filipino community.

Evaluation Tools: This objective was measured by the dates of material distribution and the number of informational materials distributed during outreach activities.

Conclusion: This agency met and surpassed its goals for objective 2. 5,090 brochures and handle tags were distributed which is 145% of the projected 3,500.

Objective 3: By December 31, 1993, this agency would have completed 100 press contacts through PSAs and press releases and conducted 40 telephone contacts related to HIV and AIDS in the Filipino community.

Evaluation Tools: The education coordinator evaluated the media activities on the number of press releases done and number of contacts made with community newspapers, radio stations and TV stations. The education coordinator also evaluated the number of interviews conducted for feature articles in the ethnic media.

Conclusion: This agency met and surpassed its goals for objective 3. 315 media contacts were made which is 315% of the 100 projected goal.

Objective 4: By December 31, 1993 this agency would have conducted or participated in 25 community meetings and made 150 telephone contacts with community health advisory councils which have been established in neighborhoods with high concentrations of Filipino residents.

Evaluation Tools: Evaluation of this objective was based on the number of meetings attended and the number of telephone contacts made with neighborhood advisory councils.

Conclusion: This agency met and surpassed its goals for objective 4. It participated in 32 community meetings, which is 128% of the projected 25 and made 244 telephone contacts, which is 162% of the projected total of 150.

Objective 5: By December 31, 1993 this agency would have developed and produced materials that would include 1,000 posters and 1,000 handbills that would convey information on "AIDS and Filipinos" and

where to go for more information or added services.

Evaluation Tools: Cultural and linguistic appropriateness of the materials would be evaluated with the participation of the neighborhood advisory councils and focus groups. The finished products would be distributed with the brochures and handbills developed in 1991 contract period.

Conclusion: The goals for objective 5 were not met as this objective was dropped during contract negotiations in order to allow FTFA to concentrate on education activities.

Name: **Forensic AIDS Project HIV/STD Education in Jails/Detention Facilities**

Funding Period: 1993

Summary: This agency achieved the goals for objectives 1, 3 and 7. It did not achieve the goals for objectives 2, 4, 5 and 6.

Objective 1: By December 31, 1993, health workers would conduct risk reduction groups for 1,200 incarcerated men and women.

Evaluation Tools: Records of sign-in/attendance sheets and participant profiles were maintained and included information on client demographic characteristics, such as: age, sex, race, sexual orientation and substance use. Other information relevant to prevention was collected during one-on-one interviews with inmates focusing on: previous sexual activity, number of sexual partners, condom usage and number of previously known STDs. The monitoring of timelines, reports and evaluations of group sessions, spot-checks to see if all points were addressed as presented in the program plan, and the usefulness of the material form and the view point of the participants was collected.

Conclusion: The goal of objective 1 was met and surpassed with the percentage of success equalling approximately 900%.

Objective 2: By December 31, 1993, this agency, in collaboration with the San Francisco Sheriff's Department, would distribute 60,000 safety kits. The kits would contain printed materials on HIV/STD/TB, hepatitis B, needle hygiene, condoms and condom usage.

Evaluation Tools: Program staff compiled, reviewed and analyzed the numbers of kits distributed and filed a written summative report for inclusion in the quarterly report. All kits were checked to assure the inclusion of relevant material.

Conclusion: This agency did not meet its goals for objective 2 as only 36,117 safety kits were distributed for a percentage of 60%.

Objective 3: By December 31, 1993 600 incarcerated individuals who were in custody less than a month and were self-identified HIV positive, or at high risk for TB, hepatitis B, and/or other STD infections would receive enhanced post-test counseling, prevention and treatment information.

Evaluation Tools: Verbal feedback from clients was used to ascertain the level and usefulness of information and/or skills learned in individual education sessions. Data was collected, and analyzed pertaining to the number of persons who commit to using a condom during sexual intercourse, the number of persons who commit to reducing the number of sexual partners and the number who commit to safer needle hygiene.

Conclusion: The goal of objective 3 were met and surpassed with the percentage of success equalling 617%.

Objective 4: By December 31, 1993, the Forensic AIDS Project would provide antibody counseling to 60 criminal justice personnel.

Evaluation Tools: All participants were asked to evaluate the service by completing a short evaluation form. Data was submitted to the AIDS Office for inclusion in the aggregate statistics. The number of people requesting testing and counseling was kept. The time between request and action was no longer than two working days.

Conclusion: The goals for this objective were not met as only 42 criminal justice personnel were counseled. However, 33 people were tested as source patients this year and all requested counseling. The intervention with source patients was not mentioned in objective 4 as one of its goals, but it was put in the annual report as a result of objective 4.

Objective 5: By December 31, 1993 500 inmates in custody for over 2 weeks would voluntarily, and confidentially be HIV tested in the San Francisco County jails.

Evaluation Tools: All inmates who were found to be HIV positive both in custody and upon release to the community were referred to resources. High-risk HIV negative individuals were counseled concerning behavior changes. Records of requests for HIV testing were kept in the Forensic AIDS Project office. All participants were asked to evaluate the service on a short form.

Conclusion: This agency did not meet its goals for objective 5. Only 429 were tested for AIDS which is 86%.

Objective 6: By December 31, 1995, 25 inmates who were identified as HIV positive while in custody would be provided joint education and counseling with their significant other(s) upon release.

Evaluation Tools: Evaluation was based on the effectiveness of recruiting inmates to participate in joint education and counseling sessions. Verbal and written feedback was taken from those who participated, with regard to the usefulness of the service. Statistical information was submitted to the AIDS Office for inclusion in the quarterly report.

Conclusion: This agency did not meet its goals for objective 6. No joint counseling sessions were held due to lack of staff, and the failure to establish voluntary HIV and TB testing. A partner notification program was scheduled for jail staff during the first quarter of 1994.

Objective 7: By December 31, 1993, 4,000 inmates when dressed into the jail would receive TB screening and be referred for HIV education.

Evaluation Tools: A log was kept with the names of those screened and tested as well as those whose tests were read in custody.

Conclusion: The goal of objective 7 was met and surpassed with the percentage of success equalling 106%. However, the annual report alludes to a statistical report that was not attached. Consequently, there may be additional data in this statistical report which would alter the success quotient for objective 7.

Name: **GAPA Community HIV Project APICA**

APICA is The Asian Pacific Islanders Consortium on AIDS and is comprised of the Gay Asian and Pacific Island Community HIV Project (GCHP), Japanese American AIDS Project (JAAP or JCYC), and the Filipino Task Force on AIDS (FTFA).

Funding Period: 1993

Summary: Fulfilled contract requirements and in some instances surpassed contract requirements.

Objective 1: By December 31, 1993 the APICA educational staff wanted to conduct 18 group educational activities for 200 gay and bisexual Asian and Pacific Islander (A/PI) men in San Francisco for the purposes of increasing knowledge of HIV and STD transmission factors and supporting attitudes and greater efficacy in risk reduction behavior.

Evaluation Tools: APICA educational staff evaluated this objective on the number of gay and bisexual A/PI men who attended the workshops and events, client demographics by ethnicity, sexual behavior and age, and a post activity test administered to at least 70% of those attending group education activities (workshops, special events, service provider trainings, speakers bureau). They projected that at least 80% of those tested would show a competent knowledge of HIV, STDs, and risk facts as well as ways to reduce risk and at least 70% would indicate significant change in attitudes and increased efficacy to negotiate and practice safer sex and other risk reduction behavior.

Conclusion: The goals of objective 1 were met and surpassed.

Objective 2: APICA projected that by December 31, 1993 the education staff would conduct 495 units of one-on-one education service. The services were projected to reach at least 300 A/PI gay and bisexual men in San Francisco.

Evaluation Tools: Process evaluations were conducted on a monthly basis by the Direct Intervention staff and the supervisors using field notes and process documentation forms to determine the number of outreach education encounters, the client demographics by ethnicity, sexual behavior and age, and the success of outreach strategies and educational encounters. Activities were documented by entries in field logs and by intake forms.

Conclusion: The goals of objective 2 were met and surpassed.

Objective 3: By December 10, 1993, APICA education staff were to conduct 250 units of media and community organizing directed towards community based bilingual media sources, and community leaders to impact community attitudes on HIV, and to improve service access of the target population of education and support services.

Evaluation Tools: Media and community organizing activities were evaluated by APICA staff documenting and rating each meeting/contact on a scale from 1-5, 1 representing an inadequate/unsuccessful contact/meeting, and 5 representing a very successful contact/meeting. Clients intaking APICA education services were asked if they were referred through a media or community referral, to evaluate the impact of this activity. This was compiled and analyzed by the end of the contract period, and reported to the AIDS Office in the final report.

Conclusion: The goals of objective 3 were met and surpassed.

Name: Glide Goodlet AIDS Project

Funding Period: 1993

Summary: The goals for objective 1 were surpassed. No other objectives were outlined in the annual report.

Objective 1: By December 16, 1993, 500 adult residents in the Tenderloin would receive AIDS and/or STD prevention and risk reduction information on how to stop the spread of STD infections as a result of street-based outreach interventions.

EvaluationsTools: Process evaluation was used to record the number of high risk clients contacted. As possible, self-reported behavior change was recorded. The staff also tracked the number and type of referrals made for all clients referred.

Conclusion: The goals for objective 1 were met and surpassed by 20%.

Name: Haight Ashbury Free Clinic

Funding Period: 1993

Summary: The goals for objectives 1, 3, 4, 6, 7, and 8 were met by this agency. However, the goals for objectives 2 and 5 were not met. Specific barriers are outlined in the conclusion section for each of these objectives.

Objective 1: New substance abuse counselors would receive HIV/pre- post-test training within 90 days of employment. HIV counseling and testing staff would participate in two trainings provided by SFDPH each quarter. In addition, staff would represent the program at the monthly CSAS HIV and Substance Abuse Task Force meetings.

Evaluation Tools: The numbers of staff members attending trainings and the numbers of staff providing in-service was documented and reported on a quarterly basis.

Conclusion: This agency met the goals for objective 1.

Objective 2: By December 31, 1993, 800 clients would be enrolled in the Haight Ashbury Free Medical Clinic (HAFMC) Substance Abuse program.

Evaluation Tools: Client demographics and service delivery information was recorded, analyzed and reported quarterly.

Conclusion: The goals for objective 2 were not met. Only 621 clients enrolled in the program which is 78% of the projected 800. Barriers identified were funding cuts and partially because of a smaller number of clients in the drug detoxification program itself. According to the annual report this agency states that the trend in the detoxification program is toward offering more comprehensive service to a smaller number of clients with increasingly complex problems.

Objective 3: By December 31, 1993, the clinic would provide 140 people with on-site confidential HIV antibody testing.

Evaluation Tools: Demographic data forms were submitted to the AIDS Office monthly and summary data was included in the quarterly reports.

Conclusion: This agency met and surpassed its goals for objective 3. 203 clients were provided with HIV antibody testing, which is 145% of the projected 140.

Objective 4: Of the 140 clients tested, 110 would return for test results and post-test counseling.

Evaluation Tools: Client information and referral information for those testing positive was recorded on the required demographic sheet and sent to the AIDS Office monthly.

Conclusion: This agency met and surpassed its goals for objective 4. 205 clients returned for testing which is 186% of the projected 110.

Objective 5: By December 31, 1993, 1,600 clients would receive risk-reduction counseling.

Evaluation Tools: Client participation on risk-reduction was documented by chart review and reported quarterly.

Conclusion: This agency did not meet its goals for objective 5. Only 541 clients participated in risk reduction which was 33% of the projected goal of 1,600. According to the agency the original goal of 1,600 assumed that the project would deliver risk reduction counseling to all clients entering the detox program. At the present level of funding the agency considers this number too ambitious and states that it was reviewed before 1994 objectives were finalized.

Objective 6: By December 31, 1993, 15 sexual partners would receive pre- and post-test counseling, early

intervention primary care if indicated, and on-going risk reduction counseling.

Evaluation Tools: Demographic forms were filled out and forwarded to the AIDS Office monthly. The number of partners participating were included in the quarterly report.

Conclusion: This agency met and surpassed its goals for objective 6. 126 clients received counseling which is 840% of the projected 15.

Objective 7: Staff would provide prevention case management to high risk HIV negative and high risk HIV positive clients.

Evaluation Tools: Staff recorded referrals made and completed in the client charts and submitted a review of such in the quarterly report.

Conclusion: This goal was met. 92 clients received prevention case management. No quantifier was identified in objective statement.

Objective 8: Clients who are HIV positive would be referred within the detox system for CD4 testing and interpretation.

Evaluation Tools: Staff recorded, in confidential medical charts, the results of providing CD4 tests to HIV positive clients.

Conclusion: The agency met its goals for objective 8. Seven clients were referred to the detox system for CD4 testing and interpretation. No quantifier was identified in objective statement.

Name: HIV Community Health Outreach Services for HIV Prevention in Drug Users

Funding Period: 1993

Summary: This agency did not provide objectives or evaluation tool information. It only gave a list of activities performed by various staff members over the course of the year. There was no information with which to compare and assess whether goals had been met. Consequently, there is no analysis of this agency's success/failure during the year of 1993.

Name: Instituto Familiar De La Raza, Inc.

Funding Period: 1993

Summary: The goals for objectives 1 and 3 were met. The goals for objective 5 were not met. 95% of the goals for objective 2 were met and 92% of the goals for objective 4 were met. Objective 4 goals were not met in terms of numbers but attitudinal changes were equal to projected goals.

Objective 1: By December 31, 1993 the agency projected they would do outreach to 100 Latina women throughout the contract period. These women would be domestic workers and food service workers. During outreach activities the women would receive a 2 to 3 minute individual intervention, a supply of condoms and educational materials, as measured by documentation of the number of safe sex supplies distributed, and by the health educator's field notes.

Evaluation Tools: Information was documented and reported by the health educator through outreach field notes, educational material distribution forms and demographic forms. The health educator spent 30 minutes a week compiling and analyzing this information, which was included in monthly and quarterly reports.

Conclusion: This agency reached and surpassed its goal for objective 1 with the percentage of success equalling 154% of targeted number of participants.

Objective 2: By December 31, 1993, 40 Latina women, recruited through outreach activities, would receive a 2 hour HIV prevention workshop. At the completion of this workshop, women would correctly identify 3-4 modes of HIV transmission, misconceptions, myths, risk reduction, and community resources. They would also indicate an increased acceptance of personal risk factors for HIV infection and for other STDs, and would identify a personal risk reduction plan as measured by pre- and post-tests. Each

women would receive a supply of condoms and educational materials and would be recruited to participate in multiple sessions. Latina PWAs would be invited as guest speakers.

Evaluation Tools: The agency identified a personal risk reduction plan, as measured by pre- and post-test and pre- and post- self risk assessments conducted by the health educator sign-in sheets and workshop report sheets filled by participants and health educator. The health educator spent two hours a month compiling and analyzing this information which was included in monthly and quarterly reports.

Conclusion: This agency achieved 95% of its target goal for objective 2.

Objective 3: Between July 1, 1993 and December 31, 1993, 12 to 15 Latina women attending the workshops would be recruited to attend three 2-hour multiple safe sex behavior change sessions. These women would demonstrate increased self esteem and empowerment, ability to initiate safe sex negotiations and conversations regarding HIV and substance abuse. These women would indicate a commitment to use of condoms with all sexual partners; not to share needles and/or to bleach them before sharing and/or to exchange them for clean ones as measured by documentation of verbal feedback and commitment from clients. A Latina PWA would be invited as a speaker/presenter in at least one of these sessions.

Evaluation Tools: Sign-in sheets and evaluation forms were completed by participants. The health educator filled out a workshop report form documenting feedback and verbal commitment from participants. The health educator spent one hour after each multiple session series compiling and analyzing this information to be included in monthly and quarterly reports.

Conclusion: This agency was successful in achieving the goals of objective 3.

Objective 4: By December 31, 1992, 100 Latino youth in San Francisco would participate in at least 4 HIV education classes conducted in targeted areas by health educators and trained peer educators. Classes would include: knowledge, positive attitudes and beliefs, self-esteem, and development of risk reduction skills and practices which support behavior change. Specific outcome objectives as measured by a post-evaluation tool, which would be conducted two to three months after the HIV education classes, would be as follows:
Knowledge: 60-70 would identify 3-4 modes of transmission/myths/risk reduction/community resources;
Attitude: 60-70 would indicate increased acceptance of personal risk factors for HIV infection and would identify a personal plan; and
Behavior: 30-40 would indicate a commitment to using condoms with all sexual partners, not share needles (if applicable), and not to have sex under the influence of drugs or alcohol.

Evaluation Tools: Evaluation tools included sign-in sheets for each class; an HIV risk assessment tool for each participant; observation of practice sessions, role plays and group discussions; and a post-evaluation tool (documented oral interview). Participant responses from the post-evaluation tool, risk assessment, and observation tool were analyzed and compared with the needs assessment (conducted during start up) to assess outcomes regarding increased knowledge, changes in attitude and belief, increase in skill, and sustained behavior change.

Conclusion: This agency was only able to provide education classes to 92 youths, which is 92% of the projected goal. However, of the participants the targeted numbers for knowledge, attitude and behavior changes were met and in the area of behavior change the goal was surpassed. This report gives some very specific information about the results of objective 4. It includes information as to who

participated in the discussions, whether the participants were skilled in cleaning needles, etc.

Objective 5: By December 31, 1993, 100 Latino youth participating in HIV education classes would receive 6 hours of follow-up support to promote self-esteem and sustain behavior change via one-on-one counseling or small group interventions. The objectives were measured by a pre- post-evaluation tool and self-reporting, which was administered 2-3 months after their HIV education classes. The specific desired outcome was:
Belief: 30-40 would demonstrate increased self-esteem; and
Behavior: 15-25 would indicate a continued commitment to use condoms with all sexual partners, not share needles (if applicable), and not have sex under the influence of drugs or alcohol.

Evaluation Tools: Progress notes were maintained on individual participants during the follow-up phase. Pre- and post-surveys were utilized to access self-esteem. Self reporting in a follow-up survey with 25% to 35% of the participants was used to determine sustained behavior change after 2 to 3 months.

Demographics were compiled and tallied in a workshop summary format for each class. Demographics, outcomes and meetings with neighborhood associations, agencies and coalitions were reported in monthly reports to the project director and reported on a quarterly basis to IFR for inclusion in their report to the AIDS Office.

Conclusion: The projected goals for objective 5 were not met. Only 3 youth participated in the program. The agency stated that the numbers were projected too high for the time allowed.

Name: National Task Force on AIDS Prevention

Funding Period: 1993

Summary: This agency reached 92% of its projected number of participants, 200% of its projected number of events and acquired 996.50 participant hours.

Objective 1: By December 31, 1993, 450 African-American gay and bisexual men would be contacted through 3 special events.

Evaluation Tools: A stamped, self-addressed postcard, which sought evaluative input from participants about each special event, was distributed upon completion of the event. Results were gathered and reported to the AIDS Office on a quarterly basis.

Conclusion: The goals for objective 1 were not met in terms of numbers of participants as there were only 417 participants spread out over 6 events. This is 92% of the projected number of participants but twice the projected number of events. Also the agency noted that they acquired 996.50 participant hours over the course of the year.

Name: **Planned Parenthood**

Funding Period: 1993

Summary: This agency did not meet its goals for objective 1. No other objectives were stated in their annual report.

Objective 1: By December 18, 1993 this agency planned to provide 250 women, who are at high risk for transmission of HIV or STD infection, with preventive educational services and accessible comprehensive health care services.

Evaluation Tools: Measurements of success were based on the following: the number of clients seen; assessment of how many clients return for their scheduled follow-up visits; whether they are seeking medical or social needs; assessment of the number of STDs diagnosed and treated; and assessment of the number of women who chose to get HIV antibody testing, and through self-reported behavior change via a short questionnaire.

Conclusion: This agency did not meet its goals for objective 1. However, only the third quarter progress report was submitted so it is possible that the numbers were reached in the fourth quarter. This is unlikely as the agency had only reached 55% of its projected clientele in the third quarter.

Name: **San Francisco City Clinic Health Education/Risk Reduction**

Funding Period: 1993

Summary: The goals of objectives 2 and 3 were met. This agency did not meet the goals of objective 1.

Objective 1: By December 31, 1993, three trainings on enhanced behavior change counseling with STD patients would be provided to City Clinic staff who perform HIV/STD risk reduction and pre- and post-test counseling.

Evaluation Tools: All staff participants completed a pre- and post-test assessment of knowledge, as well as a training evaluation. Trainers conducted a post-training assessment of counseling competency and skills through observation of simulated counseling situations. A summary of these assessments was included in the quarterly report to the AIDS Office. Annual performance appraisals included evaluation of enhanced counseling skills and competence.

Conclusion: This agency did not meet the goals of this objective although progress was made on planning and implementation.

Objective 2: By December 31, 1993, four continuing education seminars would be provided to City Clinic staff who perform HIV/STD risk reduction and HIV antibody pre- and post-test counseling.

Evaluation Tools: All participants completed a pre- and post-assessment of knowledge as well as evaluation of the seminars. A summary of these assessments was included in quarterly reports to the AIDS Office.

Conclusion: This agency met the goals of objective 2 in the second quarter.

Objective 3: By December 31, 1993, three trainings on "Integrating STD risk reduction into HIV/AIDS

Counseling" would be provided to 100 staff of CDC contracting agencies.

Evaluation Tools: All participants completed pre- and post-tests, as well as an evaluation of the training. Trainers conducted a post-training assessment of ability to integrate STD education and counseling into HIV-related counseling through observation of simulated situations. A summary of these evaluations was included in quarterly reports to the AIDS Office.

Conclusion: This agency met the goals of objective 3.

Name: **San Francisco Department of Public Health, San Francisco City Clinic HIV Counseling and Testing Service**

Funding Period: 1993

Summary: The goals for objectives 3 and 5 were met. The goals for objectives 1 and 4 were not met. 98% of the contract total for objective 2 was met.

Note: This report was very clear, concise with consistent data throughout.

Objective 1: By December 31, 1993, City Clinic staff were to provide HIV/STD prevention counseling to 7,500 patients, with the goal of reducing HIV/STD high risk behaviors in clinic patients.

Evaluation Tools: Supervisors evaluated staff providing HIV/STD prevention counseling training quarterly and providing suggestions for improvement of counseling techniques. Staff needing improvement were provided additional training. Monthly HIV pre-test counseling seminars were conducted to improve the content and quality of patient counseling. DCI staff participated in peer audits to provide each other with feedback. Staff solicited input from patients being counseled on the changes in risk behavior during the risk assessment and development of behavior change plan.

Conclusion: 81% of the goals of objective 1 were met. Barriers were identified as computer problems, staff shortages, medical triage, increased recruitment of Project Respect Research Project and document revisions.

Objective 2: By December 31, 1993 City Clinic staff would provide confidential and/or anonymous HIV testing to 5,500 patients at the STD, Glide and Ujima Clinic sites.

Evaluation Tools: Supervisors audited staff providing HIV pre-test counseling on a quarterly basis and provided

suggestions/feedback to improve quality of counseling. The number of patients receiving HIV services was compiled monthly and reported quarterly.

Conclusion: 98% of the projected goal of objective 2 was reached. Barriers identified were LVN staff shortages which resulted in closure of the clinic for testing on several occasions and medical triage efforts at City Clinic.

Objective 3: By December 31, 1993, 3,500 patients would return for HIV post-test counseling.

Evaluation Tools: HIV supervisors audit staff providing post-test counsels quarterly. Staff routinely solicited patient feedback through surveys conducted quarterly on services received and changes in risk behavior over time.

Conclusion: The goals for objective 3 were achieved and surpassed to a percentage point of 105%.

Note: The agency noted that there was a continued decline among all minority groups, particularly African-Americans, to return for their HIV test results. In order to address this the agency heightened its confidentiality procedures and collaborated with the laboratory to shorten the wait time for test results.

Objective 4: By December 31, 1993, 300 HIV positive patients would be provided with partner referral counseling and notification service.

Evaluation Tools: Supervisors evaluated HIV post-test staff semi-annually on improved techniques for providing partner referral counseling and provider assistance and partner referral follow-up services. Staff were formally evaluated in providing partner referral services as part of their annual performance appraisals. Semiannual patient surveys included questions on how HIV partner referral services could be improved and successfully provided.

Patient demographics including age, race/ethnicity, gender and sexual orientation were tabulated and compared to partner referral methods and outcomes and reported in the quarterly progress report.

Conclusion: The goals for this objective were not met. In fact only 44% of the project goals were reached.

Objective 5: By December 31, 1993, the agency would ensure that 120 HIV positive patients obtaining confidential or anonymous testing who returned for post-test counseling would be linked with HIV medical and psychosocial intervention services.

Evaluation Tools: HIV medical and psychosocial referrals for HIV positive patients documented by staff on post-test counseling summary sheets were reviewed on a monthly basis to ensure patients were being linked with needed resources. HIV resource information was reviewed and updated quarterly by HIV program staff with resource information discussed at monthly HIV post-test counselor meetings.

Conclusion: The goals for objective 5 were met and surpassed with a total of 150 patients or 125% of projected goal.

Name: UCSF AIDS Health Project

Funding Period: 1993

Summary: This agency successfully achieved the goals for objectives 1, 3 and 4. However, the goals for objective 2 were not met, having reached only 97% of the projected total.

Note: This report was very well organized with the facts plainly and simply stated. It did not suffer from the convoluted language or extraneous information so prevalent in other agency annual reports.

Objective 1: By March 30, 1993, a calendar would be developed advertising training for CDC-funded providers.

Evaluation Tools: A provider satisfaction tool was administered semi-annually to elicit provider feedback on the choice of training topics, content and quality of service delivery. The results of the survey were forwarded to CSAS.

Conclusion: The goals for objective 1 were met in the first quarter. In the fourth quarter the agency was developing the calendar for 1994.

Objective 2: By December 31, 1993, HIV Antibody pre- and post-test training sessions would be provided to 160 participants.

Evaluation Tools: All participants would complete pre- and post-test training, as well as a workshop/trainer evaluation. Participant evaluations of workshops and trainers were sent to CSAS for inclusion in the quarterly progress report.

Conclusion: This agency did not meet the goals of objective 2. However, they came close by achieving 94% of the projected number of training participants.

Objective 3: By December 31, 1993, eight topic specific trainings would be provided to CDC/AIDS Office, CSAS-funded HIV prevention providers.

Evaluation Tools: All participants completed pre- and post-test training, as well as a workshop/trainer evaluation. A follow-up test was administered to participants three months after the training. The participants' evaluations of workshops and trainers was forwarded to CSAS quarterly for inclusion in the progress report.

Conclusion: The agency met and surpassed its goals for objective 3.

Objective 4: By September 30, 1993, a specialized substance abuse training would be provided to CDC funded prevention programs that did not specialize in substance abuse counseling.

Evaluation Tools: All participants completed pre- and post-test training, as well as a workshop/trainer evaluation. Participants' evaluations of workshops and trainers were forwarded to CSAS quarterly.

Conclusion: The goals for objective 4 were met, although due to illness of training coordinator the pre- and post-tests were not completed. However participants' evaluations were forwarded to CSAS.

Name: Urban Health Study

Funding Period: 1993

Summary: This agency met and surpassed the goals of objectives 1, 2, 3, 5 and 6. It did not meet the goals of objectives 4 and 7.

Objective 1: The Urban Health Study would provide AIDS risk assessment services to 1,100 IDUs in community settings in 1993. UHS operates on a semi-annual schedule, with the goal of serving at least 550 IDUs each half-year.
Participants would undergo screening, informed consent, pre-test counseling, an AIDS risk assessment interview, and post-assessment counseling and education. Procedures would be carried out by trained health educators/interviewers (HEIs) under the supervision of the project coordinator.

Evaluation Tools: This objective was evaluated by the number of clients who completed all of the described risk assessment/testing/education procedures each six months.

Conclusion: The goals of this objective were met and surpassed with services delivered to 129% of the projected number of recipients.

Objective 2: UHS would test 1,100 IDUs for HIV-1 infection during 1993. Testing would take place with approximately 550 clients each six months, in three different high risk communities. HIF seroprevalence data would be submitted to the AIDS Office semi-annually.

Evaluation Tools: This objective was evaluated by the number of clients from whom the program obtained serum samples.

Conclusion: The goals of this objective were met and surpassed with services delivered to 129% of the projected number of recipients.

Objective 3: In 1993, UHS would conduct HIV antibody test results and AIDS risk reduction counseling with at least 880 injection drug users (80% of those who underwent risk assessment and testing). Approximately 440 HIV test results counseling sessions would take place each half year. Counseling would be provided by HEI's with special training in test results and risk reduction counseling for IDUs, under the supervision of the counseling and follow-up coordinator. Clients who receive HIV positive results would be placed in a follow-up counseling sequence.

Evaluation Tools: This objective was evaluated by the number of clients who presented themselves for, and received, HIV antibody test results and risk reduction counseling for each six months. It was also evaluated by the total percentage of clients tested who returned for their results and counseling appointments, with the goal of achieving an 80% minimum return rate.

Conclusion: The goals of this objective were met and surpassed with services delivered to 122% of the projected number of recipients. However, the annual report states that 143% of the contract was fulfilled, although the numbers in the quarterly progress reports don't support this contention.

Objective 4: UHS was to conduct 242 follow-up counseling and referral sessions with HIV seropositive clients during 1993. These sessions were to be carried out by the health educators/interviewers under the supervision of the counseling and follow-up coordinator. The number of clients would equal approximately 125 each half-year.

Evaluation Tools: This objective was evaluated by the number of HIV positive clients who attended follow-up counseling sessions and by the attrition rate between appointments.

Conclusion: The goals for objective 4 were not met. Only 66% of the projected number of recipients received services. However, the annual report states that 123% of the annual goal was reached, although the numbers reported in the quarterly progress reports don't support this contention.

Objective 5: During 1993, 300 referrals would be made to HIV-positive IDUs for medical, social and drug treatment services at the rate of approximately 150 each half-year. Ninety referrals would be tracked with clients who attended six-month follow-up sessions.

Evaluation Tools: This objective was evaluated by the total number of referrals made to HIV positive clients during follow-up counseling sessions.

Conclusion: The goals of this objective were met and surpassed with services delivered to 246% of the projected number of recipients.

Objective 6: During the project period, reports would be written examining the apparent effect of prevention efforts and association of risk factors with HIV seropositivity.

Evaluation Tools: This objective was evaluated by the number of manuscripts accepted for publication during the project period.

Conclusion: The agency met the goals for objective 6. In particular, four abstracts were submitted to the International Conference on AIDS for review; 3 poster presentations were made at the International Conference on AIDS; and 5 articles were published in established journals such as the American Journal of Public Health and the Journal of Infectious Diseases.

Objective 7: In 1993 the UHS would screen approximately 600 IDUs from its study population for latent or active tuberculosis. Given recent data suggesting that HIV + IDUs who are anergic are also at high risk for

development of TB, subjects would also be screened for anergy using two standard skin test antigens. Subjects who were eligible would receive a skin test using 5 tuberculin units of purified derivative (PPD), as well as skin testing with dermatophyton and mumps; all persons receiving a skin test would have a follow-up appointment scheduled for 48-72 hours later.

Evaluation Tools: This objective was evaluated by the number of clients screened for latent or active tuberculosis.

Conclusion: Only 40% of the goal of this objective was met.

The agency notes that the primary problem they encountered in 1993 was an increase in the demand for services and budget shortfalls as a result of seeing so many additional clients.

Name: The Wedge Program

Funding Period: 1993

Summary: The goals for objectives 1, 2, 4, 5, 6 and 7 were met. The goals for objective 3 were not met.

Objective 1: By December 1, 1993, the Wedge Program was to reach approximately 3,000 high school students with a 4-session HIV infection prevention education program. Approximately 700 students would be reached during each quarter. Of these students, 75% would indicate, through a post-intervention assessment, an increased knowledge about HIV, a positive attitude towards people with HIV and a commitment to HIV risk reduction and condom use as a result of the Wedge Program.

Evaluation Tools: The Wedge Program had undergone 2 separate evaluations which were conducted in its high school classes within SFUSD. These evaluations consistently documented the program's effectiveness in: (1) increasing the HIV knowledge of program participants; (2) increasing participating students' comfort level around people with HIV and AIDS; and (3) increased intentions to practice risk-reduction behaviors, including abstinence, safer sex and reduced use or non-use of alcohol and other substances. This agency utilized the same evaluation procedures in their 1993 program. However, even though this evaluation section states intent it does not give specifics about what sorts of evaluative mechanisms were used.

Conclusion: This agency reached and surpassed its goal for objective 1 with the percentage of success equalling 131%.

Objective 2: By December 31, 1993 the program would reach approximately 400 higher-risk youth, most of whom were in continuation, alternative and community day schools with an HIV infection prevention education program.

Evaluation Tools: Pre- and post-tests were developed and administered to a sample of these higher risk youth participants in Wedge sessions in order to quantify their change in knowledge and attitude before and after exposure to the program.

Conclusion: The goal of objective 2 was met and surpassed with the percentage of success equalling 154%.

Objective 3: By December 31, 1993 this program was to reach a total of 500 middle school students (primarily eighth graders). This HIV infection prevention education program would consist of a minimum of 4 sessions and a maximum of 5 sessions. Due to the maturity level of middle school students in the fall semester, this age group would receive the program primarily during quarters 1 and 2.

Evaluation Tools: In order to monitor program implementation, all health educators filled out an educator feedback form on each series which they presented. The director and staff reviewed these forms on a regular basis in order to identify and correct any problems in program implementation.

In order to evaluate and monitor the effectiveness, skill levels and appropriateness of individual educators and Session III (HIV+) speakers, the teachers and youth leaders were asked to complete an evaluation form for each series in their setting. In addition, the program director and experienced program educators conducted on-site monitoring of educators and speakers on a regular basis. The project director discussed and found ways to correct problems arising out of any difficulties experienced by educators and speakers. Practice sessions were arranged to work on problems, if appropriate.

Conclusion: This agency did not reach its goals for objective 3. It only supplied services to 279 youth, which is 55% of the total. However, the annual report states that the agency reached 708 youth, although the quarterly progress report numbers don't match this conclusion.

Objective 4: By December 31, 1993, one project director, two assistant health educators, one part-time health educator and speakers with HIV disease would have reached a total of 100 youth service providers and teachers who were working with highest-risk youth. The sessions would be conducted in order to facilitate communication about sexuality, HIV prevention and related topics between these service providers and their youth clients. Of those educators and service providers attending these sessions 75% would indicate greater awareness of their youths' risk for HIV infection, increased comfort in talking to youth about HIV prevention and related issues and an intent to discuss issues related to HIV infection and related issues with their clients.

Evaluation Tools: At the end of each series participating youth providers completed an evaluation form. This tool measured their satisfaction with the program as well as changes in: (1) their attitudes towards their clients' risks for HIV infection; (2) their comfort in discussing HIV-related issues with their youth; and (3) their intentions to discuss HIV infection prevention with their clients. Information obtained from these evaluations was used to improve the program's effectiveness in providing sessions to this population.

Conclusion: The goals of objective 4 were met and surpassed with the percentage of success equalling 199%. Interestingly, the program assessed that the best time to reach youth service providers was during the fourth quarter. Consequently, they experienced the most success in the fourth quarter with this objective.

Objective 5: By December 31, 1993, 150 parents and their middle school age children would participate in a total of 5 workshops at 5 middle schools, some of which would also be receiving classroom workshops.

Evaluation Tools: Each parent and student was asked to complete an evaluation form on the session they attended. This tool, which included both open-ended and close-ended questions, provided information on the impact the workshops had on parent-child communication about HIV and solicited feedback on how future sessions could further enhance participant needs.

Conclusion: The goal of objective 5 was met and surpassed with the percentage of success equalling 128%. The annual report states that the total was not met, with only 127 participants. However, from reading the quarterly progress reports there were 65 participants in the first quarter, 127 in the second quarter and none in quarters three and four. This equals 192 or 128%.

Objective 6: By December 31, 1993, staff and speakers with HIV disease would conduct two separate trainings for ten additional speakers with HIV disease and ten additional health educators in order to maintain and expand the number of effective volunteers needed to conduct all 1993 FY activities.

Evaluation Tools: Staff and consultants completed assessment forms for each potential speaker and education. In addition, participants completed evaluation forms during each day of formal training in order to determine how effective the trainings were in preparing participants to conduct sessions.
In addition once a year Session III speakers completed an evaluation that included both open-ended and closed-ended questions asking participants to self-report on their experiences with the workshops and the impact the experiences had on their lives.

An outside consultant conducted focus groups with all speakers on the impact they felt the program had on their health and well-being. Focus groups were held with speakers immediately after they completed the formal speaker training, three months after they began to conduct Session IIIs on

their own and one year after they began to work with the program.

Conclusion: The goal of objective 6 was met and surpassed with the percentage of success equalling 240%.

Objective 7: By December 31, 1993, one junior management assistant would coordinate or assist in coordinating administrative functions critical to the effective operation of this program which provides services to thousands of adolescents, parents and youth-service providers each year.

Evaluation Tools: Ongoing monitoring of the budget and all other administrative functions were carried out by the program director.

Conclusion: The goal for this objective was met.

Name: **Westside Inner-City Outpatient Services**

Funding Period: 1993

Summary: This agency met and usually surpassed its goals for objectives 1, 3, 4, 5, 6, 7 and 8. It met 98% of its goals for objective 2. However, the agency did not meet its goals for objective 9 because of funding cuts which forced it to discontinue this particular program.

Note: This annual report was contained in the report for Community Substance Abuse Services Coordination HIV Prevention In Drug Users.

Objective 1: By December 31, 1993, 280 clients would receive an individual assessment of their risk for HIV infection.

Evaluation Tools: Standard assessment information was tabulated and reported on a quarterly basis. This activity was evaluated by documenting the number of assessment protocols administered to new clients and review of the treatment plans to see if they were consistent with the identified needs.

Conclusion: This agency met and surpassed its goal for objective 1. 298 clients received HIV risk assessment which is 106% of the projected goal of 280.

Objective 2: By December 31, 1993, 280 substance abuse clients would receive HIV pre-test counseling and referral to appropriate services.

Evaluation Tools: The number of clients receiving pre-test counseling and the number of referrals made and appointments kept by the clients was documented and reported quarterly for this activity.

Conclusion: This agency almost met its goals for objective 2. 274 clients received pre-test counseling which is 98% of the projected 280.

Objective 3: By December 31, 1993 of the clients who would receive pre-test counseling 180 would elect on-site HIV testing.

Evaluation Tools: This activity was evaluated by documenting the number of HIV tests and type of counseling sessions provided. The required demographic data form was submitted to the AIDS Office by the 18th of each month.

Conclusion: This agency met and surpassed its goals for objective 3. 232 clients received an HIV antibody test which is 128% of the projected number of 180.

Objective 4: By December 31, 1993, 25 sexual and needle sharing partners would be offered HIV testing, counseling, referral for primary care and risk reduction education.

Evaluation Tools: Demographic data was completed and reported on a quarterly basis.

Conclusion: This agency met and surpassed its goals for objective 4. 30 clients received testing, counseling, referrals and risk reduction education, which is 120% of the projected goal.

Objective 5: By December 31, 1993 HIV counseling and testing staff would participate in two trainings provided by SFDPH each quarter. In addition, staff would represent the program at the quarterly AIDS Office counseling and testing meetings and CSAS HIV & Substance Abuse Task Force monthly meetings.

Evaluation Tools: The number of staff members attending the trainings and the number of staff providing in-service training was documented and reported quarterly.

Conclusion: This agency met the goals for objective 5.

Objective 6: Case management for sero-positive clients would be provided.

Evaluation Tools: Demographic information was recorded and reported, including exact descriptions of each referral.

Conclusion: This agency met its goals for objective 6. Although there was no numerical goal for clients receiving intervention, 26 clients received such intervention.

Objective 7: By December 31, 1993, 200 clients would participate in on-going groups in which HIV risk-reduction education and training took place.

Evaluation Tools: Numbers of clients in attendance were recorded and reported quarterly.

Conclusion: This agency met and surpassed its goals for objective 7. 238 clients participated in workshops addressing risk-reduction education, which is 119% of the projected 200.

Objective 8: By December 31, 1993, 50 high risk clients would receive prevention case management services.

Evaluation Tools: Numbers of clients so identified were recorded and number of PCM components in client population was recorded and reported quarterly.

Conclusion: This agency met and surpassed its goals for objective 8. 86 clients received case management services, which is 172% of the projected 50.

Objective 9: Maintain expanded HIV services to Tenderloin Detox clients.

Evaluation Tools: Client demographic information was reported on the standard form and clients were tracked in the same manner as Inner City clients.

Conclusion: The goals for objective 9 were not met as the funding was cut and the Tenderloin Detox center was discontinued.

Name: Westside Methadone Treatment Program

Funding Period: 1993

Summary: This agency met the goals for objectives 1 and 6. It did not meet the goals for objectives 2, 3, 4 and 5. However, objectives 2 and 3 met over 70% of the objective goals with funding cuts cited as a barrier. Even though goals were not met in most of the objectives the staff evaluated that the program was overall a success and that objective numbers were too high for the size of the program.

Note: This annual report was contained in the report for Community Substance Abuse Services Coordination HIV Prevention In Drug Users.

Objective 1: Throughout 1993 all new staff members would participate in a three-day training and be certified to provide HIV pre-/post-testing counseling services to clients. HIV counseling staff would also attend two trainings per quarter provided by the UCSF AIDS Health Project. In addition, staff would be represented at the AIDS Office quarterly meeting and CSAS HIV Substance Abuse Task Force monthly meetings.

Evaluation Tools: The number of staff members attending required trainings, staff certified in pre- and post- counseling and the number of staff providing in-services would be documented and reported on a quarterly basis.

Conclusion: The goals for objective 1 were met by this agency.

Objective 2: By December 31, 1993, 600 clients would be risk assessed during their first week of treatment utilizing standardized HIV/STD assessment protocols.

Evaluation Tools: Information obtained from these assessments was individualized to the counseling of clients regarding their risks of HIV disease. In addition,

assessments were summarized, analyzed and reported on a quarterly basis.

Conclusion: This agency did not meet its goals for objective 2 as only 458 clients received HIV risk assessment. This is 76% of the projected goal of 600 clients. Barriers cited were funding cuts which forced closure of methadone detox for five months.

Objective 3: By December 31, 1993 of the 600 clients assessed, 400 would be tested for HIV disease.

Evaluation Tools: Demographic forms were completed by the 15th of each month and submitted monthly to the DPH and the AIDS Office for evaluation and documentation. Separate files were kept on all HIV positive clients and updated periodically to ensure that the client was receiving and benefiting from proper medical and psychiatric care.

Conclusion: This agency did not meet its goals for objective 3 as only 312 clients received HIV tests. This is 78% of the projected goal of 400 clients. However, a higher percentage of clients elected to take the test than originally projected by two percentage points. Barriers were funding cuts which forced the methadone detox program to close for five months.

Objective 4: By December 31, 1993, 400 clients would receive on-going weekly risk-reduction counseling.

Evaluation Tools: All group and individual risk reduction sessions were documented in the client's individual chart and clients were asked, through questionnaires, to assess these services. The total number of sessions was documented, information provided was recorded and behavior changes were analyzed on a quarterly basis.

Conclusion: This agency did not meet its goals for objective 4 as only 115 clients received ongoing weekly risk-reduction counseling. This number is 29% of the projected goal of 400. The agency stated that the

objective as stated was unobtainable in this size of project.

Objective 5: By December, 1993, this agency would provide risk-reduction assessment and pre-test counseling for 200 sexual and needle-sharing partners of clients in treatment.

Evaluation Tools: The number of individual and group sessions was documented via a questionnaire and/or needs assessment interview. All required statistics were collected and required demographic forms were submitted to the AIDS Office by the 15th of each month.

Conclusion: This agency did not meet its goals for objective 5 as only 124 clients received the assessment and counseling. This is 62% of the projected number of 200. However, the staff felt that this was a successful part of the program in terms of actual risk reduction and outreach to individuals not previously exposed to HIV education, counseling and testing. The agency stated that the goal of 200 partners per year was simply too high for the size of the program and limited number of primary clients.

Objective 6: By December 31, 1993, this agency would provide HIV counseling and testing to 50 sexual and/or needle sharing partners of clients in treatment.

Evaluation Tools: Sexual/needle sharing partners of clients in treatment were asked to provide information via a questionnaire and/or needs assessment interview with respect to their activities. All required statistics were collected and required demographic data forms submitted to the AIDS Office by the end of each month.

Conclusion: The agency met and surpassed its goals for objective 6. 83 clients were counseled and tested which is 167% of the projected goal of 50.

Name: Youth Guidance Center

Funding Period: 1993

Summary: The goals for objectives 2, 4 and 5 were met by this agency. The goals for objective 1 were not met. Objective 3 achieved 93% of its projected goal. This agency produced a very informative annual report. In essence, the agency was very proud of its success in reaching youth concerning HIV education and the apparent receptivity of the workshop participants.

Note: This annual report contains an extensive evaluation of the behavior of youth before and after HIV education workshops. This information is contained in the quarterly progress reports for objective 2.

Objective 1: By December 31, 1993, project staff, in collaboration with SF AIDS Office, would provide a minimum of 10 trainings to 100 personnel (probation, detention) updating staff on prevention services, availability of HIV counseling and testing and early intervention services for youth in detention, and universal precautions in the work place. Upon agreement of training components by all parties during first quarter of grant period, trainings would be ongoing in subsequent quarters.

Evaluation Tools: Training sessions were evaluated by written self-reports by participants at the end of each session. Participants were asked to evaluate content, presenter and relevance of training to their needs. Evaluative information gathered in preliminary sessions was used to change or augment future trainings over the course of the year.

Conclusion: This agency did not meet the goals of objective 1. Only 6 trainings occurred, which is 60% of the projected 10. Also, there were 94 participants in the trainings (94%) as opposed the projected 100.

Objective 2: By December 31, 1993, project staff were to provide 1,000 incarcerated youth with: (1) information and education regarding HIV/STDs, TB, hepatitis B., HIV counseling and testing, early intervention services, and partner follow-up for sexual and needle sharing partners; (2) access to condoms upon release; and (3) follow-up in the community. The goal was to educate youth about their potential risk for HIV and other infections, and give them the opportunity to evaluate and make changes in their sexual and substance using behaviors.

Evaluation Tools: Evaluation of risk assessment and risk reduction activities included documenting the number of youth receiving individual or group education/counseling. A minimum of 250 (50%) youth going through individual assessment and condom education participated in a survey measuring knowledge, condom use and perceived future behavior regarding condom use. Evaluation of mentor training included documenting the number of participants completing the training and requiring participants to complete an evaluation tool regarding content, presenter and usefulness of the information.

Conclusion: The goals for objective 2 were met and surpassed by this agency. According to a survey used by this agency over the past two years there has been a slow, but significant, increase in condom use by youth at YGC.

Objective 3: By December 31, 1993, project social workers would provide HIV pre-test counseling to 50 youths per quarter for a total of 200 youth at YGC per grant year so that those youth at risk for HIV infection could make an informed decision regarding testing.

Evaluation Tools: Written documentation, including demographics and risk factors, were maintained in a confidential locked file on all youth who consented to confidential counseling and testing.

Conclusion: The goals for objective 3 were not met. A total of 185 youth received counseling and testing which is 93% of the projected 200.

Objective 4: By December 31, 1993, representatives from 25 youth service agencies were to have participated in monthly forums to promote citywide coordination of HIV-related services for youth.

Evaluation Tools: The evaluation tools for objective 4 were as follows: (1) prevention intervention activities to high risk youth provided through the coalition; and (2) advocacy and collaborative efforts for services to HIV+ youth. The Adolescent HIV Coalition was responsible for documenting and maintaining accurate information on work accomplished. Files were maintained by AIDS Office staff and project coordinator.

Conclusion: The goals for objective 4 were met by this agency.

Objective 5: By December 31, 1993, project staff would distribute 500 copies of the manual, "HIV and Adolescence: San Francisco 1993," to youth service agencies and providers, locally, nationally and internationally for the purpose of increasing service provider knowledge and abilities regarding HIV prevention, counseling and testing, and treatment for youth and young adult populations.

Evaluation Tools: Evaluation consisted of the compilation of the updated manual, the number produced and distribution list.

Conclusion: The goals for objective 5 were met by this agency.

Chapter 2:

Resource Inventory

Appendix C:

Matrix of 1993 HIV Prevention Programs Funded by CDC through SFDPH AIDS Office

APPENDIX C

MATRIX OF 1993 HIV PREVENTION PROGRAMS FUNDED BY CDC THROUGH SFDPH AIDS OFFICE

GROUP INTERVENTIONS

	African American	Asian / Pacific Is.	Latino / Latina	Native American	White / Caucasian
Risk Reduction Education	285 African American clients from the Western Addition, including 36 women, 117 sexually active teenagers, 110 substance users and 42 men with multiple sex partners = 237% of goal HIV/STD prevention education group presentations California AIDS Intervention Training Center AACEP (African American Community Education Project)	Over 200 gay and bisexual Asian / Pacific Islander men = over 100% of goal Group education activities APICA GAPA Project	38 Latina women = 95% of goal 2-hour HIV prevention workshop for groups of 4 to 5 women Instituto Familiar de la Raza		6 White participants Goal N/A Risk education workshops Asian American Communities Against AIDS (AACAA) Japanese Community Youth Council
	19 African American participants Goal N/A Risk education workshops Asian American C nmunities Against AIDS (AACAA) Japanese Community Youth Council	614 women, youth and members of Chinese, Southeast Asian and PI communities = 77% of annual goal by end of 2d quarter Group educational presentations Asian AIDS Project	26 Hispanic participants Goal N/A Risk education workshops Asian American Communities Against AIDS (AACAA) Japanese Community Youth Council		

	African American	Asian / Pacific Is.	Latino / Latina	Native American	White / Caucasian
Risk Reduction Education (continued)		298 Asian / Pacific Islander participants Goal was for A/PI participants only; total attendance by all ethnicities = 128% of goal Risk education workshops Asian American Communities Against AIDS (AACAA) Japanese Community Youth Council			
		589 members of the Filipino community = 168% of goal HIV/AIDS education services, primarily through 2-hour workshops Filipino Task Force on AIDS			
HIV Information and Forums	417 African American gay and bisexual men = 93% of target Special events such as parties, barbecues and performances National Task Force on AIDS Prevention	1,223 women, youth and members of Chinese, Southeast Asian and PI communities = 122% of annual goal by end of 2d quarter Participation by agency health educator in community events or forums Asian AIDS Project			

	African American	Asian / Pacific Is.	Latino / Latina	Native American	White / Caucasian
HIV Information and Forums (continued)		32 community meetings and 244 phone contacts targeting the Filipino community = 128% of goal for community meetings and 163% of goal for phone contacts Conduct or attend community meetings and contact neighborhood members of Community Health Advisory Councils to achieve community organizing goals Filipino Task Force on AIDS			
Multi-Session Education	245 substance abuse clients of agency serving African American community = at least 100% of goal Weekly meetings offering education, risk reduction strategies and support Bayview Hunter's Point Foundation		15 immigrant gay and bisexual Latino men = 100% of population goal; less than 100% of total hours goal 8 hours of risk reduction workshops per man Coalition for Immigrant and Refugee Rights and Services		
			12 Latina women = 100% of goal of 12-15 women Three 2-hour multiple safer sex behavior change sessions at women's private residences Instituto Familiar de la Raza		

	African American	Asian / Pacific Is.	Latino / Latina	Native American	White / Caucasian
Multi-Session Education (continued)			92 Latino youths = 92% of goal 4 HIV education classes Instituto Familiar de la Raza		

ONE-ON-ONE INTERVENTIONS

Ongoing Support Workshops	280 African American clients from the Western Addition, including 51 women, 50 sexually active teenagers, 131 substance users and 48 men with multiple sex partners = 583% of goal Small-group participatory peer support workshops (participants encouraged to attend 2 or more) California AIDS Intervention Training Center AACEP (African American Community Education Project)		24 immigrant gay and bisexual Latino men = 160% of population goal; less than 100% of total hours goal (goal of establishing services for youths not met) Ongoing, twice-monthly, 2-hour sessions to promote self-esteem and provide support Coalition for Immigrant and Refugee Rights and Services		

	African American	Asian / Pacific Is.	Latino / Latina	Native American	White / Caucasian
Outreach / Distribution of Materials	1,127 out-of-treatment substance user clients of agency serving African American community = 113% of goal Street outreach consisting of AIDS/STD prevention messages and materials and referral to primary health care services Bayview Hunter's Point Foundation AIDS Prevention Outreach	Over 300 gay and bisexual, Asian / Pacific Islander men = over 100% of goal Brief meetings with clients in community settings such as bars and events APICA GAPA Project	154 Latina women = 154% of goal Outreach intervention and distribution of safe sex kits and educational materials Instituto Familiar de la Raza		1 White individual Goal N/A Contact by telephone and face-to-face at program offices and community events Asian American Communities Against AIDS (AACAA) Japanese Community Youth Council
	2,950 heterosexuals at high risk for HIV transmission who are clients of agency serving African American community = 147% of goal Street or community outreach consisting of AIDS/STD prevention and risk reduction information Bayview Hunter's Point Foundation AIDS Prevention Outreach	79 Asian / Pacific Islander individuals Goal N/A Contact by telephone and face-to-face at program offices and community events Asian American Communities Against AIDS (AACAA) Japanese Community Youth Council			

	African American	Asian / Pacific Is.	Latino / Latina	Native American	White / Caucasian
Outreach / Distribution of Materials (continued)	1,129 women, clients of agency serving African American community = 112% of goal Street or community outreach consisting of AIDS prevention messages and materials and referrals for appropriate services Bayview Hunter's Point Foundation AIDS Prevention Outreach	500 brochures distributed = 100% of goal Distribute bilingual Tagalog/English AIDS brochures targeted for traditionally hard-to-reach members of the Filipino community Asian American Communities Against AIDS (AACAA) Japanese Community Youth Council			
	504 high-risk youth, clients of agency serving African American community = 50% of goal Street outreach consisting of AIDS/STD prevention messages, informational material, and referrals for appropriate services Bayview Hunter's Point Foundation AIDS Prevention Outreach	5,150 educational materials such as brochures and door-handle tags for the Filipino community = 147% of goal Distribute educational materials at community events and door-to-door Filipino Task Force on AIDS			

	African American	Asian / Pacific Is.	Latino / Latina	Native American	White / Caucasian
Risk Assessment / Education	488 substance abuse clients of agency serving African American community = 97% of goal Risk assessment and pre-testing counseling Bayview Hunter's Point Foundation	24 new clients of agency serving Asian / Pacific Islander communities = 150% of goal Risk reduction education and counseling and referrals for other services Asian American Communities Against AIDS (AACAA) Japanese Community Youth Council	250 immigrant gay and bisexual Latino men = 100% of goal Up to 1 hour of basic HIV prevention training, condom distribution and recruitment for other activities Coalition for Immigrant and Refugee Rights and Services		
	150 African American clients from the Western Addition, including 30 women, 48 sexually active teenagers, 45 substance users and 28 men with multiple sex partners = 313% of goal Individual counseling sessions California AIDS Intervention Training Center AACEP (African American Community Education Project)				
Pre-Test Counseling and Testing	113 substance abuse clients of agency serving African American community = 65% of goal HIV testing Bayview Hunter's Point Foundation				

	African American	Asian / Pacific Is.	Latino / Latina	Native American	White / Caucasian
Post-Test Counseling	53 substance abuse clients who received HIV testing at agency serving African American community = 51% of goal Post-test counseling Bayview Hunter's Point Foundation				
Case Management	60 substance abuse clients of agency serving African American community = 46% of goal Case management/ongoing prevention counseling for high risk clients Bayview Hunter's Point Foundation	4 high-risk Asian / Pacific Islander clients = 20% of annual goal by end of 2d quarter Prevention case management Asian AIDS Project			
Referral for Care	Unreported number of HIV-positive clients of agency serving African American community = 100% of goal (all clients who tested positive) Referral for primary health care and other services Bayview Hunter's Point Foundation				

	African American	Asian / Pacific Is.	Latino / Latina	Native American	White / Caucasian
Partner Notification	Unreported number of HIV-positive clients of agency serving African American community Evaluation data insufficient to report percentage of goal Partner notification assistance and partner testing Bayview Hunter's Point Foundation				
Other			3 Latino youths 3% of goal 6 hours of support and follow-up counseling Instituto Familiar de la Raza		

COMMUNITY-LEVEL INTERVENTIONS

Media Contact		Over 250 service units, for reaching Asian / Pacific Islander clients = over 100% of goal Media and community organizing APICA GAPA Project			

	African American	Asian / Pacific Is.	Latino / Latina	Native American	White / Caucasian
Media Contact (continued)		119 media outlet contacts, for reaching Asian / Pacific Islander clients = 119% of annual goal by end of 2d quarter Provide information and articles Asian AIDS Project			
		40 Chinese, Japanese, Korean, Filipino and Southeast Asian media contacts = 95% of goal Media contacts primarily in Chinese, Vietnamese or Japanese languages Asian American Communities Against AIDS (AACAA) Japanese Community Youth Council			
		315 media contacts = 315% of goal Contact Filipino American print and electronic media with educational messages Filipino Task Force on AIDS			

	African American	Asian / Pacific Is.	Latino / Latina	Native American	White / Caucasian
Community Outreach, Development, and Organizing		N/A No actual services provided as of end of 2d quarter Develop safe sex kit and handbill for reaching gay and bisexual Asian / Pacific Islander men Asian AIDS Project			
		Goal of 57 community agencies and leaders, AIDS service providers and individuals Agency was unable to report results Planning prevention strategies for Asian and Pacific Islander communities Asian American Communities Against AIDS (AACAA) Japanese Community Youth Council			

TECHNICAL ASSISTANCE, TRAINING AND REPORTS

	African American	Asian / Pacific Is.	Latino / Latina	Native American	White / Caucasian
Technical Assistance / Training	Unreported number of staff of program serving African American substance abuse clients = less than 100% of goal of 2 trainings per quarter Counseling and testing staff participation on SFDPH trainings Bayview Hunter's Point Foundation	11 volunteers = 46% of annual goal by end of 2d quarter Training to provide HIV/AIDS information to Asian / Pacific Islander clients Asian AIDS Project	5 immigrant gay and bisexual Latino men = 50% of goal by end of 3d quarter (goal of 3 youths not met) HIV/STD prevention training as *promotores* Coalition for Immigrant and Refugee Rights and Services		
Reports	230 evaluation surveys of agency serving African American community = 19% of goal KABB surveys of IDUs, youth at risk and women to evaluate changes in knowledge, behaviors and attitudes about HIV issues Bayview Hunter's Point Foundation AIDS Prevention Outreach				

GROUP INTERVENTIONS

	Gay/Bisexual Men	Women	Transgender	Youth
Risk Reduction Education	Over 200 gay and bisexual Asian / Pacific Islander men = over 100% of goal Group education activities APICA GAPA Project	36 African American women from the Western Addition = 120% of goal for women HIV/STD prevention education group presentations California AIDS Intervention Training Center AACEP (African American Community Education Project)		127 parents and middle-school-age children = 85% of goal Workshops introducing parents to classroom workshops to be offered and designed to facilitate parent-child communication about sexuality, HIV prevention and related topics The Wedge Program
		38 Latina women = 95% of goal 2-hour HIV prevention workshop for groups of 4 to 5 women Instituto Familiar de la Raza		117 sexually active African American teenagers from the Western Addition = 390% of goal for all teenagers HIV/STD prevention education group presentations California AIDS Intervention Training Center AACEP (African American Community Education Project)
		Unreported number of Chinese, Southeast Asian and PI women = 77% of annual goal by end of 2d quarter for all clients (614 total clients) Group educational presentations Asian AIDS Project		Unreported number of Chinese, Southeast Asian and PI youth = 77% of annual goal by end of 2d quarter for all clients (614 total clients) Group educational presentations Asian AIDS Project

	Gay/Bisexual Men	Women	Transgender	Youth
Risk Reduction Education (continued)		179 Asian / Pacific Islander women Goal N/A Risk education workshops Asian American Communities Against AIDS (AACAA) Japanese Community Youth Council		251 Asian / Pacific Islander youth aged 12-19 Goal N/A Risk education workshops Asian American Communities Against AIDS (AACAA) Japanese Community Youth Council
		4,348 incarcerated women Goal N/A Risk reduction workshops Forensic AIDS Project		
HIV Information and Forums	417 African American gay and bisexual men = 93% of target Special events such as parties, barbecues and performances National Task Force on AIDS Prevention	Unreported number of Chinese, Southeast Asian and PI women Goal N/A Participation by agency health educator in community events or forums Asian AIDS Project		Unreported number of Chinese, Southeast Asian and PI youth Goal N/A Participation by agency health educator in community events or forums Asian AIDS Project
Multi-Session Education	15 immigrant gay and bisexual Latino men = 100% of population goal; less than 100% of total hours goal 8 hours of risk reduction workshops per man Coalition for Immigrant and Refugee Rights and Services	12 Latina women = 100% of goal of 12-15 women Three 2-hour multiple safer sex behavior change sessions at women's private residences Instituto Familiar de la Raza		3,852 high school youth = 128% of goal 4-session HIV prevention education program The Wedge Program

	Gay/Bisexual Men	Women	Transgender	Youth
Multi-Session Education (continued)	200 gay and bisexual male clients of substance abuse clinic = 100% of goal Weekly risk reduction and education groups 18th Street Services Street Outreach	42 female Latina youths Goal N/A 4 HIV education classes Instituto Familiar de la Raza		744 higher-risk youth, most of whom are in are in continuation, alternative and community day schools = 184% of goal HIV prevention education programs averaging 4 hours The Wedge Program
				708 middle school youth = 142% of goal 4- or 5-session HIV prevention education program The Wedge Program
				92 Latino youths = 92% of goal 4 HIV education classes Instituto Familiar de la Raza

ONE-ON-ONE INTERVENTIONS

Ongoing Support Workshops	24 immigrant gay and bisexual Latino men = 160% of population goal; less than 100% of total hours goal (goal of establishing services for youths not met) Ongoing, twice-monthly, 2-hour sessions to promote self-esteem and provide support Coalition for Immigrant and Refugee Rights and Services	51 African American women from the Western Addition = 425% of goal for women Small-group participatory peer support workshops (participants encouraged to attend 2 or more) California AIDS Intervention Training Center AACEP (African American Community Education Project)		50 sexually active African American teenagers from the Western Addition = 417% of goal for teenagers Small-group participatory peer support workshops (participants encouraged to attend 2 or more) California AIDS Intervention Training Center AACEP (African American Community Education Project)

	Gay/Bisexual Men	Women	Transgender	Youth
Ongoing Support Workshops (continued)				Over 1,000 youths in detention Goal was not reported by service provided; goal of providing services to 1,000 youths in detention was met Group meetings focusing on building self-esteem, decision-making and communication skills, and on subjects related to adolescent sexuality Youth Guidance Center
Outreach / Distribution of Materials	Over 300 gay and bisexual, Asian / Pacific Islander men = over 100% of goal Brief meetings with clients in community settings such as bars and events APICA GAPA Project	154 Latina women = 154% of goal Outreach intervention and distribution of safe sex kits and educational materials Instituto Familiar de la Raza		Over 1,300 youths, 618 of whom were in detention Goal was not reported by service provided; goal of providing services to 1,000 youths in detention was met Condom education and distribution Youth Guidance Center
		1,129 women, clients of agency serving African American community = 112% of goal Street or community outreach consisting of AIDS prevention messages and materials and referrals for appropriate services Bayview Hunter's Point Foundation AIDS Prevention Outreach		504 high-risk youth, clients of agency serving African American community = 50% of goal Street outreach consisting of AIDS/STD prevention messages, informational material, and referrals for appropriate services Bayview Hunter's Point Foundation AIDS Prevention Outreach

	Gay/Bisexual Men	Women	Transgender	Youth
Outreach / Distribution of Materials (continued)		36 Asian / Pacific Islander women Goal N/A Contact by telephone and face-to-face at program offices and community events Asian American Communities Against AIDS (AACAA) Japanese Community Youth Council		12 Asian / Pacific Islander youth under age 20 Goal N/A Contact by telephone and face-to-face at program offices and community events Asian American Communities Against AIDS (AACAA) Japanese Community Youth Council
Risk Assessment / Education	250 immigrant gay and bisexual Latino men = 100% of goal Up to 1 hour of basic HIV prevention training, condom distribution and recruitment for other activities Coalition for Immigrant and Refugee Rights and Services	138 women at high risk for transmission of HIV or STD infections = 55% of goal as of 3d quarter Preventive educational services via group and individual education sessions Planned Parenthood		520 youths in detention Goal was not reported by service provided; goal of providing services to 1,000 youths in detention was met Comprehensive health assessment Youth Guidance Center
	240 gay and bisexual male clients of substance abuse clinic = 100% of goal Risk assessment and follow-up group or individual counseling 18th Street Services Street Outreach	30 African American women from the Western Addition = 250% of goal for women Individual counseling sessions California AIDS Intervention Training Center AACEP (African American Community Education Project)		48 sexually active African American teenagers from the Western Addition = 400% of goal for teenagers Individual counseling sessions California AIDS Intervention Training Center AACEP (African American Community Education Project)

	Gay/Bisexual Men	Women	Transgender	Youth
Risk Assessment / Education (continued)		10 new female clients of agency serving Asian / Pacific Islander communities Goal N/A Risk reduction education and counseling and referrals for other services Asian American Communities Against AIDS (AACAA) Japanese Community Youth Council		23 new clients under age 20 of agency serving Asian / Pacific Islander communities Goal N/A Risk reduction education and counseling and referrals for other services Asian American Communities Against AIDS (AACAA) Japanese Community Youth Council
Pre-Test Counseling and Testing	60 gay and bisexual male clients of substance abuse clinic = 60% of goal HIV testing and counseling 18th Street Services Street Outreach			185 youths in detention = 93% of goal Pre-test counseling and HIV testing Youth Guidance Center
Case Management	37 gay and bisexual male clients of substance abuse clinic = 74% of goal Case management for high risk clients 18th Street Services Street Outreach			
Referral for Care	7 seropositive gay and bisexual clients of substance abuse clinic = 14% of goal, representing 100% of clients newly identified as seropositive Referral to qualified sites for primary care 18th Street Services Street Outreach			

	Gay/Bisexual Men	Women	Transgender	Youth
Partner Notification	69 gay and bisexual male clients of substance abuse clinic = 69% of goal Counseling on partner notification options 18th Street Services Street Outreach			
Other	100 gay and bisexual male clients of substance abuse clinic = 100% of goal Evaluation and needs assessment questionnaire 18th Street Services Street Outreach	1 female Latina youth Goal N/A 6 hours of support and follow-up counseling Instituto Familiar de la Raza		512 youths in detention Goal was not reported by service provided; goal of providing services to 1,000 youths in detention was met Individual counseling about sexuality, safe sex behaviors and the use of condoms Youth Guidance Center
				3 Latino youths = 3% of goal 6 hours of support and follow-up counseling Instituto Familiar de la Raza

COMMUNITY-LEVEL INTERVENTIONS

Community Outreach, Development, and Organizing	N/A No actual services provided as of end of 2d quarter Develop safe sex kit and handbill for reaching gay and bisexual Asian / Pacific Islander men Asian AIDS Project			

TECHNICAL ASSISTANCE, TRAINING AND REPORTS

	Gay/Bisexual Men	Women	Transgender	Youth
Technical Assistance / Training	5 immigrant gay and bisexual Latino men = 50% of goal by end of 3d quarter (goal of 3 youths not met) HIV/STD prevention training as *promotores* Coalition for Immigrant and Refugee Rights and Services			199 youth service providers, primarily middle and high school teachers, who work with highest-risk youth = 199% of goal Training session to facilitate communication about sexuality, HIV prevention and related topics between service providers and youths The Wedge Program
				24 educators and 18 HIV-positive speakers = 240% of goal for educators and 180% of goal for HIV-positive speakers Training for participation in agency's programs The Wedge Program
				94 Youth Guidance Center personnel = 94% of goal Training on prevention services, availability of HIV counseling and testing and early intervention services for youth in detention Youth Guidance Center
				Unreported number of representatives from youth service agencies Goal was participation by representatives from 25 agencies Participation in Adolescent HIV Coalition to promote city-wide coordination of HIV-prevention services for youth Youth Guidance Center

	Gay/Bisexual Men	Women	Transgender	Youth
Technical Assistance / Training (continued)				500 copies of manual = 100% of goal Distribute manual entitled "HIV and Adolescence: San Francisco 1993" to youth service agencies and providers locally, nationally and internationally Youth Guidance Center
Reports		Unreported number of evaluation surveys women clients of agency serving African American community Goal N/A KABB surveys of IDUs, youth at risk and women to evaluate changes in knowledge, behaviors and attitudes about HIV issues Bayview Hunter's Point Foundation AIDS Prevention Outreach		Unreported number of evaluation surveys of youth clients of agency serving African American community Goal N/A KABB surveys of IDUs, youth at risk and women to evaluate changes in knowledge, behaviors and attitudes about HIV issues Bayview Hunter's Point Foundation AIDS Prevention Outreach

GROUP INTERVENTIONS

	Substance Use / IDU	Partner of IDU	Sex Worker / Prostitute	Other / Undefined
Risk Reduction Education	110 African American substance users from the Western Addition = 367% of goal for substance users HIV/STD prevention education group presentations California AIDS Intervention Training Center AACEP (African American Community Education Project)			13,732 incarcerated men and women = 1,144% of goal Risk reduction workshops Forensic AIDS Project
Multi-Session Education	200 gay and bisexual male clients of substance abuse clinic = 100% of goal Weekly risk reduction and education groups 18th Street Services Street Outreach			
	238 clients = 119% of goal Ongoing HIV risk reduction workshops Westside Inner-City Outpatient Services			
	245 substance abuse clients of agency serving African American community = at least 100% of goal Weekly meetings offering education, risk reduction strategies and support Bayview Hunter's Point Foundation			

ONE-ON-ONE INTERVENTIONS

	Substance Use / IDU	Partner of IDU	Sex Worker / Prostitute	Other / Undefined
Ongoing Support Workshops	131 African American substance users from the Western Addition = 1,092% of goal for substance users Small-group participatory peer support workshops (participants encouraged to attend 2 or more) California AIDS Intervention Training Center AACEP (African American Community Education Project)			
Outreach / Distribution of Materials	1,127 out-of-treatment substance user clients of agency serving African American community = 113% of goal Street outreach consisting of AIDS/STD prevention messages and materials and referral to primary health care services Bayview Hunter's Point Foundation AIDS Prevention Outreach			601 high-risk residents of the Tenderloin neighborhood = 120% of goal Street-based outreach interventions Glide Goodlet AIDS Project
Risk Assessment / Education	240 gay and bisexual male clients of substance abuse clinic = 100% of goal Risk assessment and follow-up group or individual counseling 18th Street Services Street Outreach	124 sexual or needle-sharing partners of clients in treatment = 62% of goal Risk reduction and pre-test counseling Westside Methadone Treatment Program		6,087 City Clinic patients = 81% of goal HIV/STD prevention counseling SFDPH SF City Clinic HIV Counseling and Testing Service

	Substance Use / IDU	Partner of IDU	Sex Worker / Prostitute	Other / Undefined
Risk Assessment / Education (continued)	1,415 IDU's in the Western Addition, Tenderloin and Mission districts = 129% of goal Risk assessment counseling and education Urban Health Study	126 sexual or needle-sharing partners of clients for risk reduction education; 49 partners for testing = 840% of goal for education; no goal reported for testing Risk reduction education and HIV testing Haight Ashbury Free Clinic		42 criminal justice personnel = 70% of goal Pre-test counseling Forensic AIDS Project
	458 clients = 76% of goal HIV risk assessment Westside Methadone Treatment Program			
	298 clients for risk assessment and 274 clients for pre-test counseling and referrals = 106% of goal for risk assessment and 98% of goal for pre-test counseling Risk assessment, pre-test counseling and referrals for other appropriate services Westside Inner-City Outpatient Services			
	621 clients = 78% of goal Enrollment in agency's substance abuse program, which includes risk assessment and reduction counseling Haight Ashbury Free Clinic			

	Substance Use / IDU	Partner of IDU	Sex Worker / Prostitute	Other / Undefined
Risk Assessment / Education (continued)	541 clients = 33% of goal Risk reduction counseling Haight Ashbury Free Clinic			
	488 substance abuse clients of agency serving African American community = 97% of goal Risk assessment and pre-testing counseling Bayview Hunter's Point Foundation			
	45 African American substance users from the Western Addition = 375% of goal for substance users Individual counseling sessions California AIDS Intervention Training Center AACEP (African American Community Education Project)			
Pre-Test Counseling and Testing	1,415 IDU's in the Western Addition, Tenderloin and Mission districts = 129% of goal HIV antibody testing Urban Health Study	2 sexual or needle-sharing partners of gay and bisexual male clients of substance abuse clinic = 13% of goal HIV testing 18th Street Services Street Outreach		5,372 City Clinic patients = 98% of goal Confidential or anonymous HIV testing SFDPH SF City Clinic HIV Counseling and Testing Service

	Substance Use / IDU	Partner of IDU	Sex Worker / Prostitute	Other / Undefined
Pre-Test Counseling and Testing (continued)	312 clients = 78% of goal HIV testing Westside Methadone Treatment Program	83 sexual or needle-sharing partners of clients in treatment = 167% of goal HIV testing and counseling Westside Methadone Treatment Program		314 inmates who either requested or were ordered to undergo HIV testing Goal was 500 inmates to be voluntarily, confidentially tested HIV testing Forensic AIDS Project
	229 clients = 127% of goal HIV testing Westside Inner-City Outpatient Services	30 sexual and needle-sharing partners of clients = 120% of goal HIV testing, counseling, and risk reduction education Westside Inner-City Outpatient Services		
	236 clients = 169% of goal HIV testing Haight Ashbury Free Clinic	25 sexual or needle-sharing partners of African American substance abuse clients = 125% of goal HIV test, pre- and post-test counseling and case management Bayview Hunter's Point Foundation		
	60 gay and bisexual male clients of substance abuse clinic = 60% of goal HIV testing and counseling 18th Street Services Street Outreach			

	Substance Use / IDU	Partner of IDU	Sex Worker / Prostitute	Other / Undefined
Pre-Test Counseling and Testing (continued)	113 substance abuse clients of agency serving African American community = 65% of goal HIV testing Bayview Hunter's Point Foundation			
Post-Test Counseling	1,075 IDU's in the Western Addition, Tenderloin and Mission districts = 122% of goal Post-test counseling Urban Health Study			3,676 City Clinic patients = 105% of goal Post-test counseling SFDPH SF City Clinic HIV Counseling and Testing Service
	458 clients Goal N/A (Goal was reported only for weekly post-test counseling) Post-test or risk reduction counseling, including weekly counseling for 115 clients at especially high risk Westside Methadone Treatment Program			At least 857 self-identified high-risk inmates and at least 3,705 individual counseling sessions At least 143% of goal for number of inmates; no goal reported for number of sessions Enhanced post-test counseling, prevention and treatment information Forensic AIDS Project
	155 clients = 141% of goal Post-test counseling Haight Ashbury Free Clinic			

	Substance Use / IDU	Partner of IDU	Sex Worker / Prostitute	Other / Undefined
Post-Test Counseling (continued)	53 substance abuse clients who received HIV testing at agency serving African American community = 51% of goal Post-test counseling Bayview Hunter's Point Foundation			
Case Management	37 gay and bisexual male clients of substance abuse clinic = 74% of goal Case management for high risk clients 18th Street Services Street Outreach			
	26 seropositive clients Apparently met goal of providing service to all seropositive clients Ongoing health service case management Westside Inner-City Outpatient Services			
	86 high-risk clients = 172% of goal Prevention case management Westside Inner-City Outpatient Services			

	Substance Use / IDU	Partner of IDU	Sex Worker / Prostitute	Other / Undefined
Case Management (continued)	92 high-risk clients, both seropositive and seronegative No goal reported for number of clients Prevention case management services Haight Ashbury Free Clinic			
	60 substance abuse clients of agency serving African American community = 46% of goal Case management/ongoing prevention counseling for high risk clients Bayview Hunter's Point Foundation			
Referral for Care	7 seropositive gay and bisexual clients of substance abuse clinic = 14% of goal, representing 100% of clients newly identified as seropositive Referral to qualified sites for primary care 18th Street Services Street Outreach			150 HIV-positive patients = 125% of goal Referral for HIV medical and psychosocial intervention services SFDPH SF City Clinic HIV Counseling and Testing Service
	161 seropositive IDU's in the Western Addition, Tenderloin and Mission districts Goal not stated in terms of number of IDU's served; goals exceeded for number of sessions and referrals Follow-up counseling, including 740 referrals for medical, social and drug treatment services Urban Health Study			

	Substance Use / IDU	Partner of IDU	Sex Worker / Prostitute	Other / Undefined
Referral for Care (continued)	7 HIV-positive clients of substance abuse program No goal reported for number of clients Referrals for CD4 testing and interpretation Haight Ashbury Free Clinic			
Partner Notification	69 gay and bisexual male clients of substance abuse clinic = 69% of goal Counseling on partner notification options 18th Street Services Street Outreach			133 HIV-positive patients = 44% of goal Partner referral and notification services SFDPH SF City Clinic HIV Counseling and Testing Service
Other	100 gay and bisexual male clients of substance abuse clinic = 100% of goal Evaluation and needs assessment questionnaire 18th Street Services Street Outreach			36,117 safety kits, condoms or pieces of HIV/STD literature = approximately 60% of goal of 60,000 safety kits Distributions of materials to incarcerated men and women Forensic AIDS Project

TECHNICAL ASSISTANCE, TRAINING AND REPORTS

Technical Assistance / Training	N/A = 100% of goal Substance abuse counselor training 18th Street Services Street Outreach			Goal was not targeted to clients Goal was met Calendar advertising training for CDC-funded providers UCSF AIDS Health Project

	Substance Use / IDU	Partner of IDU	Sex Worker / Prostitute	Other / Undefined
Technical Assistance / Training (continued)	Unreported number of new staff members at agency = 100% of goal to train all new staff members Training to provide pre- and post-test counseling Westside Methadone Treatment Program			151 AIDS pre- and post-test counselors = 94% of goal 3-day training sessions UCSF AIDS Health Project
	Unreported number of staff members of agency = goal to participate in training Trainings by SFDPH and meetings with City AIDS Office and CSAS HIV and Substance Abuse Task Force Westside Inner-City Outpatient Services			131 counselor participants Goal to hold 8 training sessions was surpassed Specialized trainings on specific topics such as cultural competency in the provision of services, transgender issues, and immigration and HIV counseling and testing UCSF AIDS Health Project
	Unreported number of new and current substance abuse staff of agency = 100% of goal to provide training for staff HIV pre- and post-test counseling training for new staff and update trainings for current staff Haight Ashbury Free Clinic			36 counselors and health care providers Goal to hold 1 training session was met Specialized substance abuse training for CDC-funded prevention programs that do not specialize in substance abuse counseling UCSF AIDS Health Project

	Substance Use / IDU	Partner of IDU	Sex Worker / Prostitute	Other / Undefined
Technical Assistance / Training (continued)	5 substance abuse service providers = goals for technical assistance Provide technical assistance, program monitoring and evaluation Community Substance Abuse Services Coordination HIV Prevention in Drug Users			5 staff members No goal reported for number of staff members Training for staff who perform risk reduction and pre- and post-test counseling on enhanced behavior change counseling with STD patients San Francisco City Clinic
	Unreported number of staff of program serving African American substance abuse clients = less than 100% of goal of 2 trainings per quarter Counseling and testing staff participation on SFDPH trainings Bayview Hunter's Point Foundation			At least 53 staff members No goal reported for number of staff members Participation in continuing education seminars on HIV and STD's and interpretation of risk assessment forms San Francisco City Clinic
				116 participants = 116% of goal Training sessions for staff of CDC-contracting agencies on integrating STD risk reduction into HIV/AIDS counseling San Francisco City Clinic
Reports	5 manuscripts published No quantitative goal Write reports examining the apparent effect of prevention efforts and association of risk factors with HIV seropositivity Urban Health Study			

	Substance Use / IDU	Partner of IDU	Sex Worker / Prostitute	Other / Undefined
Reports (continued)	Unreported number of evaluation surveys of IDU clients of agency serving African American community Goal N/A KABB surveys of IDUs, youth at risk and women to evaluate changes in knowledge, behaviors and attitudes about HIV issues Bayview Hunter's Point Foundation AIDS Prevention Outreach			

This matrix compiles interventions by target population for 1993 programs funded by the CDC through the SFDPH AIDS Office. Each entry (1) describes the recipients of the intervention; (2) indicates to what extent the intervention met process goals established by the agency; (3) describes the specific services the agency provided; and (4) lists the agency's name.

Some interventions were provided to clients who belong to two or more target populations. As an example, a program might have provided counseling and testing services to gay African American substance-using men. An individual intervention provided to such clients is recorded in every appropriate target population column, although the cells describing the intervention are shaded after the first time the intervention appears in the matrix.

Data for the matrix is taken from annual reports the CDC required the agencies to submit to the AIDS Office. Data on the recipients of each intervention is included only to the extent that it was reported by each agency. Data on process goals is listed as "N/A," denoting "not available," when an agency reported serving clients it had not specifically targeted.

Chapter 3:

Strategies and Interventions

CHAPTER 3: STRATEGIES AND INTERVENTIONS

Introduction

This chapter offers findings about current and future strategies and interventions, and about the ideas and opinions of members of target populations, prevention providers and funders. The findings lead to a number of recommendations relating to the planning and delivery of appropriate HIV prevention services for specific target populations.

Data for this chapter was gathered from the following sources:

- Focus groups of members of target populations
- Community meetings
- Self-reporting from prevention service providers in interviews, discussions and written reports
- Appropriate published research literature
- Key informant interviews
- Group interviews and discussions among HIV Prevention Planning Council members

In almost all instances, the findings stop short of stating that a particular intervention has proven effective to prevent HIV infections in a given population. Focus groups and key informants were selected by sub-committees of the Council in order to add perspective to existing data. Although the available pool of data includes a great deal of qualitative information and a number of conclusions based on published research, the data evaluating the impact of specific interventions is too limited to support definitive statements about their ability to stop the spread of HIV in particular San Francisco populations.

Nonetheless, much is known about HIV prevention strategies and interventions. This chapter begins with some overarching themes. It then turns to specific target populations to examine their attitudes toward HIV and their current risk behavior. Next, it offers some general conclusions about the effectiveness of particular strategies and interventions. Finally, it identifies unmet needs and offers recommendations.

Common Themes in HIV Prevention in San Francisco

Commonly-held fears, frustrations, goals and beliefs point to core issues that threaten the effectiveness of HIV prevention strategies and interventions. This section discusses these common issues and how the data suggests they should be addressed.

Self-Esteem Issues

Self-esteem issues come up in many target populations for HIV prevention services. They are reflected in the specific actions members of target populations take when faced with a decision whether to protect themselves, and are the product of broad dynamics in the community at large. Members of target populations indicate that while they know what specific actions are necessary to protect themselves, they do not always engage in safe behavior.

- Self-esteem issues arise when many focus group participants say they follow the cues of their partners rather than assert their own needs.

  As an African American gay male focus group participant says, "Where I may want to practice safe sex, the person I'm with may not be there. Sometimes I have a problem demanding that this needs to go on. Sometimes I may be somewhat passive."

Broad forces in the community at large affect self-esteem issues.

- Focus group participants of all demographic groups say the community at large doesn't care about them.

  This sentiment, although common to most focus group participants, is expressed most strongly by transgender people, who believe quite simply that the community wants them to disappear.

- Self-esteem issues are rooted in larger problems such as discrimination, substance abuse and poverty.

  Data from focus groups, key informants and providers demonstrate that effective prevention planning requires dealing with issues such as substance use, homelessness and joblessness that diminish self-esteem or distract individuals from being able to focus on protecting themselves from HIV infection. As a key informant states, "Some of these people are too busy surviving to worry about living."

- Providers say that gender plays a role in how self-esteem issues affect behavior.

  This point is borne out in focus group data. For example, a Latina woman focus group participant says building self-esteem in girls will give them "the courage to ask the questions, when they become sexually active, about their potential partner."

- Self-esteem issues are heightened when people lack power and personal responsibility in the processes of planning and providing HIV prevention services.

  Research and the experiences of providers and key informants suggest that members of target populations should be involved in prevention planning, and services should involve them by integrating HIV into the other concerns they face. Such involvement is one of three elements of community-level interventions, which research indicates show promise of being especially effective in changing behavior (1). As a key informant notes, "More monetary and technical support needs to be placed in the hands of those closer to the community and viewed by the community as being committed and dedicated to making a change and improving life for them. The community needs to feel heard and responded to."

The Role of Communities in Planning Strategies and Interventions

- Members of target groups say they want a role in helping themselves.

  Many focus groups culminated in a spontaneous movement to form an organization to take prevention messages back to the community. In the Latino IDU focus group, a participant suggested, "Say we start a club up. Or, an organization. Of ourselves. Get a president, vice president, secretary, everything. And get organized. And go to somebody higher up that can give us some advice. . . . And then we can get our own little pamphlets printed up, [and] when we get educated, we can educate more people, and we can invite people, have seminars, once a week."

  An African American female focus group participant says, "Give us a chance to help ourselves." Research corroborates the effectiveness of involving community members in planning and providing prevention services (1).

- Providers and key informants say public health and community groups should collaborate to design appropriate services.

  Community empowerment models that include the community in planning and implementation of prevention programs while addressing other social factors give a community the ability to take care of its own, providers say. A key informant adds, "The Public Health Department has access to information needed by the community and the community knows its people. They need to collaborate and work together."

Recognizing the Culture, Needs and Norms of Targeted Groups

- Research and other data shows that each risk group should be approached through its own language and cultural norms (1).

  Each community has its own culture and language; youth reflect different values than middle-aged men than heterosexual young women than the Spanish-speaking community, etc. Prevention efforts must take account of the various attitudes prevalent among target communities to enable people to protect themselves within the context of their own culture.

Many people of color say they feel overlooked by current services.

- People of color feel current prevention efforts are aimed at white people, according to focus group participants and key informants.

  Efforts directed at people of color are perceived as insensitive to their needs. As one key informant notes, under the present system "you have some people trying to give a message to a group that has been trained to tune them out." Another key informant says that HIV prevention messages are ineffective because they "are not targeted toward any cultural groups in particular" and "most often relate to the dominant culture."

Providers say that group norms and the motivations of target populations also should be considered when planning prevention programs.

- Group norms should be modified to change behavior.

  Research and the experience of providers shows that interventions that change group norms can alter individual behavior (1). Providers report that individuals cannot be expected to change their own behavior if the behavior of their

peers is not changing. Community-level interventions are needed to change group norms, providers say.

- Prevention providers say they should examine motivations to design programs that respond to the needs of clients.

  Research data, focus groups and key informants say prevention services should appeal to the identified needs of target populations (1). Providers note that members of target populations can be encouraged to follow prevention messages if they are approached as consumers of services. Prevention services should reach people in their daily lives. They should motivate people to be safe.

Attitudes Toward HIV

In addition to the broad themes outlined above, several specific attitudes toward HIV emerged from the data. Fear of HIV infection, hopelessness about becoming infected and denial of HIV risk are among the most common attitudes expressed by members of high-risk populations.

Fear

- Many focus group participants report being afraid of contracting HIV.

  Fear shows an awareness of risk, either real or perceived, of contracting HIV. Fear is expressed especially strongly by injection drug users (IDUs). As an African American IDU says, "My life revolves around sex and drugs. Now both of those mean the same thing: death. It's one slip—either one—and I'm going to die. That's a continuous fear, a daily fear. It's not like going outside and worrying about a drive-by. It's inside and outside, all day long and all night long."

  People may modify their behavior to alleviate fear. But a significant number of focus group participants, especially gay and bisexual men and IDUs, believe they will become infected because they do not or cannot modify their behavior according to prevention messages.

- Many focus group participants believe HIV is easily transmitted and question whether prevention is possible.

  For example, some participants in the Latino IDU focus group believe that HIV can be spread by sharing a cigarette. Similarly,

many focus group participants question the safety of sexual intercourse with a condom, and question their ability to protect themselves.

- Some focus group participants believe their own infection is inevitable.

  For example, a young African American gay male focus group participant reports he will come to grips with HIV "when I do become HIV positive, probably."

Denial

According to focus group participants, many members of target populations deny their own risk of contracting HIV.

- Denial is a pervasive attitude reported by focus group participants regardless of racial and risk behavior classifications.

  People in denial may engage in risky behavior or refuse to find out whether they are infected with HIV. As an African American gay male focus group participant states, "A lot of our Black brothers and sisters are not being tested. They refuse to even go and find out if they are HIV-positive. And if they do find out, they don't tell their sex partners." Young Asian/Pacific Islander gay male focus participants say some of their peers feel "invulnerable and invincible."

- Substance use contributes to denial, according to focus group participants.

  Providers and focus group participants note the relationship between substance use and awareness of HIV risk. As a transgender focus group participant says, "Whenever the girls are either high or drunk, that impairs their awareness that they have to have safe sex. Each and every time."

- Even when they are aware of their risk, focus group participants say cultural attitudes about homosexuality and promiscuity keep them from protecting themselves.

  For example, a Latina woman focus group participant describes a prevailing view of sex in her culture as follows: "You're either like this virgin or the opposite. There's very little in-between. I'm college educated. I went to graduate school. There's still among the men this mentality that if you come up with a

condom you're like some whore. . . . It's very demeaning if you're in the position, and very isolating. We're in 1994, but I don't think some of the stereotypes and the progression of the way women are seen by Latino men have changed."

An African American gay male focus group participant says, "In the African American Community, it is really a hard thing to look at. Because the first thing that comes up when you are HIV-positive is: you must be dealing with homosexual practices. . . . So if I don't say nothing and don't do nothing, it won't cause all of that other peer pressure to come at me."

Similarly, low-income African American women focus group participants believe that the majority of their partners have been incarcerated and have had homosexual experiences in prison or jail. The women nonetheless say they are not comfortable asking about their partners' sexual histories. These findings corroborate the need to modify community norms that challenge the ability of people to protect themselves.

Hopefulness

- Some focus group participants indicate they believe they can avoid becoming infected.

While fear, hopelessness and denial are common, many people, especially gay men who have lived with the epidemic for more than a decade, have developed constructive attitudes toward HIV prevention. Gay men report being particularly confident they can control their risk. Some focus group participants say they discuss safe and unsafe sexual practices with their friends. They also say they learn from their losses. For example, one gay male focus group participant says he knew his friends' sexual practices, and now knows what's safer based on who's still alive.

Current Behavior

This section reviews the current sexual and needle-using behavior of members of target populations. It also discusses multiple-risk behavior.

Sex

- According to research and focus group participants, many people report using condoms only occasionally (1,2,3).

  Members of all focus groups report there is "lots" of unsafe sex in their communities.

- Researchers have noted differences in condom use habits among different target populations.

  For example, research indicates that African American gay men have much more unprotected anal intercourse than white gay men (3).

- Many focus group participants say they set their own rules for condom use.

  For example, they use condoms with new partners but not with regular partners, or they use condoms only when their partner insists. Key informants corroborate this finding.

- According both to focus group, published research and key informant data, some people believe partners who do not appear ill do not have HIV (1).

  As a key informant states, young people "tend to believe, 'If I've seen you more than twice, and you don't appear to be sick, you are safe.'"

- Focus group data shows condom use is especially low during oral sex.

  People say condoms reduce sexual pleasure and oral sex carries a low risk of HIV transmission.

- A notable minority of focus group participants think all sex is unsafe.

Needle Sharing

- Most IDU focus group participants say they do not regularly share needles.

  Most, however, say they have shared needles at one time or another.

- Many IDU focus group participants who currently do not share needles believe they inevitably will have to share in the future.

- Research shows that needle sharing behavior varies somewhat based on race, age and the drugs used.

  According to published research, IDUs reporting any use of cocaine were more likely to report needle sharing. Older IDUs were less likely to report needle sharing. Blacks reported less sharing than did whites (11).

Multiple Risks

- Gay and transgender focus group participants report their peers are less safe when multiple risks, such as substance use and sexual activity, are involved.

  As a gay man states, "You are far more apt to engage in risky behavior if you've done too much drugs or too much alcohol. I think it's a point that's overlooked. When you're drunk, your guard's down."

- Some IDU focus group participants, however, downplay the connection between substance use and unsafe sex.

  As an African American IDU says, "Actually, even before HIV and everything, I actually never wanted to have sex when I used drugs." One of his peers explains, "It would depend on what type of drug I was using. Cocaine and speed has a tendency, for me, to arouse my sexuality. Time to get it on, after you got hit, but with heroin it's more sedate."

- Published research and focus group data shows that increased needle safety among IDUs is not associated with increased condom use (4,9).

  As an African American IDU says, "I use condoms occasionally. I know it's weird, taking all these precautions about not catching HIV through using dirty outfits and then going right ahead and having sex without any protection."

Current Prevention Strategies and Interventions

A comprehensive inventory of strategies and interventions used in San Francisco is included in the previous chapter. Although as noted in the Introduction, current data, both qualitative and quantitative, is insufficient to say definitively which strategies and interventions are effective to prevent new HIV infections in particular populations, this section draws general conclusions about certain strategies and interventions from the available data.

1. Individual-level Interventions

Street and Community Outreach

Street and community-based outreach programs are widely used to reach large groups of people. Outreach workers provide services to persons where they are in their natural settings, and serve as links between programs and communities. In San Francisco, trained community health outreach workers (CHOWs) conduct direct AIDS education, including distribution of condoms, bleach, and educational materials, with community members (7).

- Research and other data show street outreach is successful in communicating prevention messages to many populations and is associated with behavior changes, especially when it involves peer leaders, targets particular communities and reaches them near the location of risky behavior (8,9).

  It is notable that street and community-based outreach services are the only intervention proven in published research to be somewhat successful with youths, one of the most difficult groups to reach with prevention messages (8).

- Research data, focus group participants, key informants and providers all emphasize that outreach services must be appropriate to the target population and its norms (10).

  Clients should be able to identify with outreach workers. For example, research shows using outreach workers from the community contributes to the positive impact of outreach programs targeting IDUs.

  Research has shown that staff who were from the targeted community and population were more likely to gain access to sex workers and became role models for behavior change (3).

- Outreach service providers say consistency in outreach workers is important to the success of outreach programs.

  High turnover among outreach workers is a problem because rapport between the worker and the community is vital to the success of outreach programs.

  Building trust with members of the target population has been found to be an important factor for continued participation of the target population (3).

- Outreach providers also indicate that to be more effective over time, outreach contacts must be repeated regularly or include follow-up support.

Counseling, Testing, Referral, and Partner Notification

HIV counseling, testing, referral, and partner notification services provide an opportunity for people to learn about their serostatus, receive prevention counseling, referrals and information relevant to their needs, and receive assistance in notifying partners (11).

Counseling and testing play a prominent role in prevention programs. Recently, however, researchers have noted that "counseling and testing are not up to the task of behavior change and should never have been the centerpiece of HIV prevention programs. Counseling and testing certainly have a place, but not the central place in HIV prevention." (10)

- Some research suggests counseling and testing programs have not resulted in significant behavioral change Yet other research has shown that counseling and testing was fairly effective in reducing high risk behavior in the gay population specifically (12).

  Among drug users that were tested for HIV, improved self-efficacy to avoid HIV infection was associated with learning that one was HIV negative (13).

- Prevention providers, however, say counseling and testing services can motivate individuals to recognize their risk, ask questions about safer sex in a safe environment, and formulate personal risk reduction plans.

  Prevention providers also say they are able to identify new target populations through counseling and testing programs. They note that demand for testing is large.

The CDC has adopted a new model for counseling and testing based on client-centered behavior changes. Although it is too early to evaluate the model, it might increase the effectiveness of counseling and testing programs.

Needle Exchange

Needle exchange programs are those that provide sterile needles to injection drug users in exchange for their used equipment.

- Needle exchange programs are among the most effective interventions for HIV prevention (10, 14).

  Many studies have reported that needle exchange programs have played a significant role in lowering rates of needle sharing and have served as sources of referrals for drug treatment and other services (6, 14).

  Published research suggests needle exchange programs can reduce high risk drug behaviors, although the impact of needle exchange programs on sex behaviors is unclear (1, 6).

  Many IDU focus group participants say they regularly exchange needles. In addition to preventing new HIV infections, IDU focus group participants credit needle exchange programs with providing them access information about other services such as detox programs.

Initial results indicate that needle exchange programs are cost effective.

  Mathematical models of needle exchange programs "suggest that needle exchange programs can prevent significant numbers of infections among clients of the programs, their drug and sex partners, and their offspring. In almost all cases, the cost per HIV infection averted is far below the ... lifetime cost of treating an HIV-infected person" (6).

- A variety of factors may limit the effectiveness of needle exchange programs, including a lack of resources and of information in target communities about existing services.

  Providers note that overall only a fraction of IDUs use needle exchanges. And IDUs who would utilize needle exchange

programs do not always know how to access them. For example, some IDU focus group participants in the Tenderloin are not aware of the schedule for needle exchanges and do not realize the service is available in their general neighborhood almost daily.

- Providers note that IDUs do not always consider needle exchange sites to be safe.

  Providers say IDUs fear that law enforcement officials or social service authorities will intercept them at needle exchange sites. Providers also say that some women IDUs fear their children will be taken from them if they participate in needle exchange programs.

Hotline

Hotlines are toll-free anonymous lines staffed by volunteers who provide education, referrals, support and risk assessment to callers.

A study of repeat callers to an HIV/AIDS hotline whose only source of HIV/AIDS information was the hotline reported an increase in the practice of safe sex. This included increase in use of condoms and abstinence from sex (15)

Individual Peer Education (also see Peer Education section below)

Individual peer education includes any one-on-one intervention conducted by someone who is a peer of the client.

Prevention Case Management

Prevention case management provides individualized counseling, information, and referral to individuals who are at risk for HIV infection. Prevention case management assists individuals to develop and implement personalized risk reduction programs.

2. Group-level Interventions

Small Group Interventions

Small group-based interventions can be single or multiple session groups where education, information, social support, and referrals are provided.

Small group discussion format has been shown to be effective in promoting safer sexual behaviors and intentions among young urban African American crack cocaine users (16)

•Group counseling interventions effectively increase knowledge about HIV and AIDS and decrease high-risk behavior, according to published research (1,17).

For example, a study of predominantly white, college-educated gay men found a program of sex negotiation skills training, stress reduction training, intensive group counseling and information to eroticize safer sex materials modified risk behavior on a short-term basis (17).

Multiple session groups are structured groups which provide HIV/AIDS/STD prevention information and skill building but often include other topics related to prevention, such as self-esteem and other psychosocial issues.

A study of African American gay and bisexual men in San Francisco demonstrated that men who participated in multiple session groups had higher levels of behavior change, and maintained behavior change over time than those who attended single sessions groups (18).

An evaluation of a six-session skill-building intervention conducted with high school students demonstrated that this approach was effective in increasing STD and AIDS knowledge and increasing skills to prevent risky sexual behaviors, but not drug use behaviors (19).

- According to service providers, multi-session group interventions have a greater impact on participants than single-session interventions.

Providers note, however, that single-session interventions are also effective and give access to members of target populations who would not attend multi-session programs. Group interventions are more effective when they address other social

or personal issues such as racism, domestic violence or poverty, providers say.

Larger Group Interventions

Group presentations are defined as groups where 15 or more participants attend sessions in which speakers present information and facilitate skill building activities. Presentations may be conducted by peers or by others with expertise in HIV/AIDS information and skill-building.

Group Peer Education (see Peer Education Section)

3. Community-level Interventions

Community based approaches to behavior change provide information and skills to change behavior and encourage a supportive social environment through channels and methods that are indigenous to the community. Community-level efforts are also designed to create structures and systems which assist in the maintenance of healthy behaviors. These interventions are based on several theories including social learning theory, the health belief model, attitude change theory and diffusion theory (20)

Social Marketing and Use of Media

Social marketing involves the production of a message disseminated through a mode that is appropriate and effective for the target population. Social marketing includes the development of a marketing plan, the design of message, use of mass media, consensus building, and packaging (20).

Media, both general and that directed at specific subgroups in the communities, is influential in teaching about the health risks associated with specific behaviors (20).

- According to published research and other data, media campaigns with culturally-appropriate messages effectively convey prevention information and change behavior when funding exists to sustain them over time (10).

  Media campaigns often require a substantial amount of funds, and therefore many grassroots movement-type organizations cannot afford to sponsor them. Also, several complaints about current media campaigns emerged from focus group data.

- Some focus group participants report being overwhelmed or confused by the variety and inconsistency of media messages.

For example, messages concerning the safety of oral sex sometimes are confusing or inconsistent.

- Many focus group participants complain that media efforts do not depict peers of target group members.

  For example, African American gay male focus group participants complain that posters only show white people or don't show male couples.

- Media providers note that media messages must be strong to compete for the public's attention.

  Desensitization of the public from exposure to many strong messages, however, is a countervailing concern.

- Providers note that messages are most effective when they are emotionally or intellectually engaging.

  To engage a particular population, providers say media messages should be integrated with other issues and activities of the targeted group. The target population also should be involved in planning and implementing a media campaign.

Community Mobilization/Organization

Community mobilization and organization involves community-wide efforts which bring together members of the targeted community to address the issue of HIV. Strategies used to bring members of the community together vary according to the needs and characteristics of the target population. The theoretical underpinning of community organization for health behavior change is based in several theories including social learning theory, the health belief model, attitude change theory and diffusion theory (20)

> A community-level approach developed and implemented by peers of the target population was effective in decreasing unprotected anal intercourse relative to those in a control community (21).
>
> Effective organization of the gay and bisexual community in San Francisco in the mid to late 1980s contributed to the dramatic decrease in unprotected anal intercourse that decreased HIV transmission during that period (20).

4. Peer Education

The importance of peers as educators is based in diffusion of innovation theory. Diffusion theory suggests that information and learning flows through natural social networks; people are more likely to adopt new behaviors if they are introduced by someone who is similar to them and is perceived to be a role model (20, 3). Peers are identified by how you define who you are trying to reach. Therefore peer educators may be similar to the target population by behavior, culture, race, age, ethnicity, gender, or other factors salient to the target population.

Since peer norms appear to be important influences on adolescent behavior, peer education can assist in changing the perception of norms with respect to HIV and risk behaviors (22).

> Research has shown that successful adolescent peer educators "evaluate AIDS information for authenticity, reconstruct it for themselves and their peers, and use their own personal or vicarious experiences as filters through which they interpret and pass along information and advice (16)."

Current research indicates that HIV prevention delivered by peers may be viewed as more credible and sensitive than interventions delivered by local, state, or federal health officials (23).

A study of African American youth in San Francisco, indicates that participants in a peer-led skills training regard peer education as useful and important (16).

A small pre and post-survey of out-of-school youth who participated in group peer education indicated increased level of knowledge and intention to use condoms. This group indicated that they were more likely to ask questions about sex to peer educators than adults (24).

An assessment of the HIV prevention needs of gay and bisexual men of color found that programs that were the most effective for HIV prevention among gay men of color are those run by and for gay men of color (25).

Unmet Needs

The data from focus groups, providers and published research points to a number of areas in which services do not meet existing needs. The following discussion identifies these unmet needs.

- Focus group participants say additional support services are needed, especially for people of color.

  According to focus group participants, people of color believe that support services for them are limited or are underfunded. Also, members of these communities say they are not fully aware of the services targeted toward them.

  As an African American gay male states, "It is strange that to this day, that this group of people who are getting infected—the people of color. If you notice, the organizations for people of color are small, very limited, and in the strangest places. . . . But you see big Shanti, you see big AIDS Foundation. . . . When we go there, it's like, 'Fill this out, do this, do that, and we'll get back to you.'" Only young gay Asian/Pacific Islander male focus group participants feel services targeting their population are adequate.

- Focus group participants and providers say more street and community-level outreach is needed, including information about existing services.

  An African American IDU says, "many people out there do not know about African American agencies, but agencies do exist." Even people who are generally aware of the availability of services will not take advantage of them absent a concerted outreach effort.

- Focus group participants of all populations say they want more small group programs.

  Although providers note that not everyone who says they want small groups would actually attend them, many focus group participants said they appreciated being brought together in a group of peers and expected that prevention information would be shared. They asked for "more groups like this"—meetings of peers from their own community to discuss HIV prevention.

To be effective, providers say groups should be conducted in natural settings and should take into consideration issues other than HIV facing members. Because they only reach small numbers of people at a time, other strategies such as media are needed to reach large populations.

- Focus group participants who have not already had many personal interactions with HIV-positive peers say such contact is a primary motivation for changing their behavior.

  For example, a gay Asian/Pacific Islander male focus group participant described contact with an HIV-positive peer of the same age and background as follows: "It's boom! It's just a, like a catalyst! Like, 'Hey, I can get this, too!' Because what differentiates him from me?"

  This theme emerged from almost all focus groups. Research, however, suggests that interaction with HIV-positive individuals does not necessarily result in increased safer sex behavior. For example, while researchers say strong relationships with people with HIV or AIDS in the early years of the epidemic was associated with adoption of safer sex behavior among gay and bisexual men according to initial research, researchers say that more recent findings do not show that such contact for gay and bisexual men results in changed behavior.

- Focus group participants and providers agree prevention messages should be clarified.

  Focus group participants of all populations are confused about the safety of condoms and bleach, how HIV is transmitted and what a negative test result means. As one example among many, a key informant reports that in the African-American community, "anything that involves contact with skin is perceived to be unsafe."

- Oral sex messages in particular should be simplified.

  Although research has not been able to exactly fix the risk of unprotected oral sex, providers say consistent messages can be developed to reflect the state of knowledge. They suggest that messages should instruct that unprotected oral sex without ejaculation is not as high a risk as unprotected vaginal or anal

intercourse, which is highly unsafe. People who are resistant to condom use should understand the risks they take.

- Providers say multiple-risk behavior should be addressed in an organized and consistent manner.

  Social and health service programs addressing one risk factor should also address others as appropriate, providers say. For example, programs addressing substance use should address safe sex issues. This will require cross-training in various fields for providers.

- IDUs focus group participants say they need additional treatment opportunities.

  IDU focus group participants express frustration that effective drug treatment programs currently have long waiting lists.

- Providers say programs should offer attendance incentives.

  Examples of effective incentives are food, clothing, public transit passes and other basic needs, providers say.

- Planning should take into account evolving HIV-negative and HIV-positive subcultures, providers say.

  Providers say prevention planning should consider how one's HIV status, whether positive, negative or unknown, relates to behavior.

- In planning prevention services, providers say the issues of infection and reinfection should be explored more fully to determine whether they do or should motivate HIV-positive individuals to engage in safer behavior.

  Condom use also is important for HIV-positive individuals because they are at greater risk for worse consequences from other sexually-transmitted diseases.

- Both providers and research indicate that sustained interventions are important, and may in fact be a key, to the effectiveness of many interventions (10).

Recommendations

1. Consistent and uniform impact and process evaluation data should be collected using client surveys and convenient samples of target groups. Data should be collected in a way that is sensitive to community norms but should be uniform across information types. The AIDS Office should fund community development of appropriate, valid evaluation techniques using the expertise of researchers.

2. Substance abuse treatment services should be better coordinated with HIV prevention services.

3. In developing HIV prevention programs, successful techniques that address other behavior change issues in target communities should be examined.

4. To ensure consistency and effectiveness in prevention activities, appropriate funding should be provided for sustained, multi-intervention HIV prevention programs.

5. The AIDS Office should convene an appropriate group to formulate a consistent, clear message for San Francisco concerning the safety of unprotected oral sex. The AIDS Office should encourage all San Francisco providers to use this message to ensure that it is translated to communities at risk.

6. Needle exchange programs should be provided in safe and secure settings, keeping in mind the privacy concerns of clients.

7. More HIV prevention programs should be provided, including small group, street outreach, community-level outreach and community advocacy interventions. These programs should be developed in light of the cultural context of target communities and the social context in which risk behavior occurs, involving the community in the planning, implementation and delivery of services.

8. When appropriate, prevention programs should provide clients incentives for participation such as food, clothing and transit passes.

9. Because research is important in making funding decisions, and because new issues and unmet needs often are identified before there is corroborating published research, appropriate pre-publication research data should be distributed on an expedited basis to assist prevention planning.

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Chapter 4:

Priority Setting Criteria

CHAPTER 4: PRIORITY SETTING CRITERIA

Introduction

As outlined in the CDC Guidance, one of the essential purposes of HIV Prevention Community Planning is to establish a "participatory process which results in programs that are responsive to high priority, community-validated needs within defined populations." The purpose of the Priority Setting Criteria chapter of this plan is to articulate a means to identify these "high priority, community-validated needs."

The following section identifies those criteria for selecting priorities in four areas: target groups, strategies, resource allocation and research. In each area the actual criteria are preceded by guiding principle(s) for using these criteria.

A. PRIORITY TARGET GROUPS

Principle:

> There is only one factor for determining which populations need focused prevention efforts: namely, a significant risk of contracting HIV. Risk of contracting HIV is caused by practicing certain, identifiable, behaviors.

This plan is concerned with the prevalence of HIV in the city of San Francisco.

According to the CDC, as of December, 1993, San Francisco has the highest rate (287.5 per 100,000) of AIDS cases of any metropolitan area in the United States. Therefore, all people in San Francisco who practice behaviors that could lead to the transmission of HIV are at high risk for contracting HIV. For example:

> If a woman has sex with any man in San Francisco her odds of having sex with a man who is HIV-infected are: 1 in 140. If restricted to men who have sex with women this ratio changes to: 1 in 160.
>
> If a man has sex with any man in San Francisco his odds of having sex with a man who is HIV-infected are: 1 in 80. If restricted to men who have sex with men this ratio changes to: 1 in 4.

However, the prevalence of HIV in any population means nothing in the absence of behavior; therefore if we consider all San Franciscans to be at high risk due to

the presence of the virus in our region, we must make efficiency of HIV transmission our next level of criteria. From most effective transmission to least effective within each category, the following are the primary factors for selecting priority target groups.

Primary Factors

BLOOD to BLOOD:
Injection drug use
Perinatal
Cunnilingus during menses
Other blood to blood

SEMEN to BLOOD:
Anal receptive
Anal insertive
Vaginal
Fallatio

VAGINAL Secretion to BLOOD:
Vaginal (female to male)
Cunnilingus

VAGINAL Secretion to VAGINAL (hypothetical: no current epidemiological evidence)

Physiological Co-Factors

Beyond the actual behaviors, co-factors will be considered which increase the risk of contracting HIV with a given behavior. These co-factors are to be used along with the primary factors listed above in determining priority of risk groups. Co-factors include poverty, age, substance use, and other factors which increase the efficiency of transmission of HIV.

For example it has been demonstrated that the health of poor women is compromised by typically inadequate nutrition; in particular, the vaginal walls are weaker and more susceptible to bleeding. Thus, poverty as a co-factor places low-income women at a greater risk than other women for contracting HIV through semen to blood transmission during intercourse.

Substance use has been shown to be linked with various dimensions of decreased health status including thin cell walls, pseudo anemia, and poor nutrition. Age has been linked with decreased resistance to disease in general. Other physiological co-factors may be considered based on scientific evidence.

The presence of more than one behavioral or physiological co-factor may well have a "multiplier-effect" in terms of risk of infection. This issue is not addressed specifically in these criteria beyond the data that currently exists.

Behavioral Co-Factors

The criteria for identifying target risk groups are the behaviors which put people at risk of contracting HIV. The following types of information will be used to inform the identification of groups practicing high risk behaviors, and to better understand the existence and causes for high risk behavior.

Epidemiological data, including incidence and prevalence of HIV, and various surrogate markers provide evidence that high risk behavior is taking place. As the quality and consistency of these measures increases, changes in these measures over time will be one source of data to track changes in behaviors.

Evidence of high risk behavior and attitudes which are linked with high-risk behavior are clearly essential to the identification of relevant priority sub-groups for prevention efforts. Knowledge, Attitudes, Beliefs and Behavior Studies (KABBs), documented program service data and the experience of providers are all sources of information about the extent and nature of high-risk behavior in population sub-groups.

In addition, issues such as low knowledge or situational factors related to high-risk behavior (such as incarceration) are to be considered when establishing and defining the target groups for prevention efforts.

B. SELECTION OF STRATEGIES

Principle:

Strategies will be consistent with the values, norms, and consumer preferences of the intended target population.

Criteria:

- Effectiveness: *evidence of effectiveness will include formal studies, outcome evaluation studies and the experience of providers.*
- Cost effectiveness: *the number of infections averted per dollar spent on prevention.*
- Scientific theory: *theoretical models of behavior change.*
- Speed of implementation: *for example, with a start-up program, if an intervention can be implemented more quickly than an alternative intervention, this is an advantage, all else being equal.*

C. RESOURCE ALLOCATION

Principles:

To prevent as many infections as possible with limited resources, intensive prevention efforts should be targeted to groups and individuals at higher risk. Nonetheless, basic (non-targeted) prevention information and activities must be available at some level to every individual or group no matter how small the risk.

Further, this Planning Council actively supports the mobilization of other resources to assure that all needs are identified and addressed.

Criteria:

These criteria will be applied during the resource allocation process, after priority target populations have been identified, in the development of RFPs and proposal evaluation .

- Size of target population
- The impact of HIV on a given population: *impact is a function of prevalence and size of population. A high prevalence in a small population is of additional concern because of the disproportionate burden borne by that community.*
- Availability of other (non-DPH) resources for priority populations
- Populations historically underserved by HIV prevention activities

D. RESEARCH PRIORITIES

Principle:

The guiding principle for research topics is to find out what we most need to know about populations at high risk and populations which may be at high risk but about which there is little data.

Criteria:

- The effectiveness of various strategies and interventions.
- Populations: examples include service providers know that a population is at risk, but no HIV prevalence data exists for that population, a population's status as historically under-studied, reported increases in demand for services in a population, and significant increases in the rate or absolute number of positive HIV tests or AIDS diagnoses in a population.
- Cost-effectiveness analyses and research on inputs for these analyses.

Chapter 5:

Summary and Needs Assessment

CHAPTER 5: SUMMARY AND NEEDS ASSESSMENT

I. INTRODUCTION

> *"Since I've been here in San Francisco, in some of the agencies that I've tried to go to, there's waiting lists, or they tell you to 'Call me next month, and I'll see if I have room on my list for you then.' And I mean, I think what I'm saying is that there needs to be more of what is already there. Nobody's trying to take away from what you guys are doin'. You guys are doing an excellent job. But there's only so many of you. You guys get overloaded. You know what I mean?"*
>
> *-- Transgender Focus Group Participant.*

> *"When I see a real cute Latino or Asian guy, I have to really, really think before I act, and I'm just surprised that I'm not positive yet, because sometimes, I really have a hard decision on whether I should use safe sex or not safe sex."*
>
> *-- Young African American Gay Man.*

The complex, intricately woven pattern of a comprehensive HIV needs assessment is, in the end, only as strong as the threads of conversations such as these, spoken by people for whom this disease has become part of the fabric of their daily lives.

Perhaps the most difficult challenge facing any planning body charged with creating such a comprehensive needs assessment is how to best synthesize these qualitative, individualized and often emotion-laden personal experiences and opinions with quantitative factual and statistical epidemiologic data.

This challenge is heightened when that same body must weave the various strands of this needs assessment together without the benefit of a pre-set framework or easily measurable goals. Prevention work inherently requires a large degree of abstraction: measuring who is *not* getting sick is a far more difficult task than charting the course of those who *are* sick.

The Centers for Disease Control itself recognizes both the importance and the difficulty of combining both quantitative and qualitative elements in a needs assessment. In its guidance to community planners, the CDC states, "Participatory community planning is an essential component of effective HIV prevention programs. This type of planning is *evidence-based* (i.e. based on HIV/AIDS epidemiologic surveillance and other data, ongoing program experience, program evaluation, and a comprehensive, objective needs assessment process) and incorporates the views and perspectives of the groups at risk for HIV infection/transmission for whom the programs are intended, as well as the providers of HIV prevention services...Priority setting accomplished through a participatory process will result in programs that are responsive to high priority, community validated needs within defined populations. HIV prevention programs developed without community collaboration are unlikely to be successful in preventing the transmission of HIV infection or in garnering the necessary public support for effective implementation."[1]

Taken as a whole, the preceding four chapters form the evidence-based framework upon which the needs assessment must be woven, and individual chapters have also started creating the pattern upon that fabric.

In Chapter One, the Epidemiologic Profile presents a detailed picture of the current state of the epidemic in San Francisco, and projections of the directions which it will take in the near future. Utilizing both traditional epidemiologic data-gathering methodologies as well as an extensive literature review, the profile offers the most comprehensive document of its kind to be produced to date.

Similarly, Chapter Two provides an inventory of the resources currently being used in San Francisco to fight the epidemic. While this inventory centers primarily upon data surrounding government-funded programs, there is also some information included for non-government-funded programs. This chapter also provides information on funding and program data, as well as an initial analysis of the barriers to achieving service goals.

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[1]Supplemental Guidance on HIV Prevention Community Planning for Noncompeting Continuation of Cooperative Agreements for HIV Prevention Projects; Centers for Disease Control; U.S. Department of Health and Human Services, Washington, D.C., January 1994.

The inventory in turn serves as the foundation for Chapter Three, which analyzes the efficacy of the strategies and interventions in use. This Summary of Findings further explores the barriers which prevent these strategies from attaining maximum effect. In conjunction with information gathered through other standard needs assessment methodological practices (focus groups, key informant interviews, community forums, and surveys), this chapter also presents an analysis of the efficacy and adequacy of current prevention services in San Francisco, and recommendations for how these strategies and interventions can be improved in the future.

Finally, Chapter Four identifies a formula of priority-setting criteria to be applied to the epidemiologic data. By focusing attention on behavior and transmission information, this formula serves as the basis through which both high risk activity and behavior as well as target populations and communities can be identified.

The body of this chapter completes the picture of the epidemic in San Francisco through the following steps:

1) Identifying overarching themes for prevention in San Francisco (i.e. those themes which apply to all or almost all groups of people, regardless of race, ethnicity, gender, sexual orientation, etc.);
2) Identifying the priority unmet prevention needs which grow out of these themes for specific target populations, and;
3) Recommendations for future needs assessment planning.

By so doing, this chapter sets the stage for the Prevention Plan, which will be described in detail in Chapter Six (Priority Goals and Objectives), Chapter Seven (System Linkages and Coordination), and Chapter Eight (Technical Assistance).

II. IDENTIFICATION OF OVERARCHING PREVENTION THEMES FOR SAN FRANCISCO

> *"My son was very ill when he was 10 months old. He was in the hospital for about a month. He had a very low immune system. They came in to tell me that something was wrong with his immune system. Right there I said, 'I'm dying.' I said, 'I have AIDS. My son has AIDS. We're gonna die.' They tested both of us and we were fine and I knew. But I thought maybe something happened, because I used to do a lot of drugs."*
> *-- Latina Woman*

Certain themes regarding prevention needs are common to all populations affected by HIV and AIDS. Like the disease itself, the issues of homophobia, fear of the inevitability of contracting HIV, mixed messages regarding safe and unsafe behavior, and misinformation about HIV transmission cross all normative boundaries to strike at every affected community.

Those groups at highest risk, however, experience heightened difficulties in dealing with unmet needs, because their problems are exacerbated by societal and cultural influences. For instance, gay youth of color must often confront violently homophobic cultural attitudes in addition to the already difficult experiences of "coming out" and learning about sexual activity. IDU men and women often rate the threat of HIV and AIDS infection as relatively minor problems when compared to the more pressing demands of daily survival.

In each of the target population synopses presented in the next section, unmet needs are depicted as they specifically apply to these groups. While this type of analysis is useful in describing the needs of particular finite populations, such compartmentalization and fragmentation runs the risk of minimizing the importance of needs which may apply across-the-board to <u>all</u> populations, but are not dominant to any <u>one</u> target group.

What follows in this section, then, is a broad-based, thematic exploration of central unmet needs faced by all communities which are grappling with the issues of HIV prevention and infection. These themes fall into the following primary core issues:
1) HIV prevention strategies targeting IDU activity must also address sexual behavior modification;
2) HIV prevention strategies must address non-IDU substance use issues as well as IDU activity.

3) HIV prevention messages must reach beyond behavior modification to address sociological and psychological issues such as self-esteem and the importance of community membership;
4) Information on prevention services and programs must be gathered in a manner which enables measurement of unmet needs;
5) Services must be targeted at who is at highest risk, and perceptions of service decisions must be need-based, not politically-based;
6) Transmission information and education must be delivered in a clear, concise, and culturally appropriate manner.

These core themes emerge from a variety of sources: epidemiologic data, behavioral data, literature reviews, focus groups, individual interviews, and community input. In the remainder of this section, each of these themes will be expanded and developed in greater depth, together with recommendations for how to help achieve these goals.

- **HIV Prevention Strategies Targeting IDU Activity Must Also Address Sexual Behavior Modification.**

For every target population, regardless of race, ethnicity, gender, or age, the highest risk of HIV infection occurs among IDU people who have sex with men. And for every one of these populations, IDUs regularly report that although they often adapt their IDU behavior to incorporate safer drug use, they just as often do not modify sexual behavior to engage in safer activity. In addition, IDUs are disproportionately represented among homeless and transient populations.

In order to be successful, then, programs targeting IDUs must address HIV infection in the larger context of how the disease affects people's daily lives, and not just how a particular manifestation of behavior might be altered by a specific intervention. For instance, the problem of IDUs engaging in high risk sex cannot be solved simply by handing out condoms. While at first glance this may seem to be a logical intervention, it addresses only the fact that IDUs engage in sex, and ignores the greater, more important issues of when and how IDUs engage in risky behavior. It is not realistic to expect people who engage in sex while under the influence of drugs, or those who must trade sex in order to get drugs, to demand condom use under such situations.

Programs which include condom distribution in conjunction with education, street outreach, needle exchange, and referrals for mental health and treatment will more closely meet the needs of IDUs. These programs must be delivered in a culturally competent manner (i.e. taking into context the links between race/ethnicity and drug preference sub-group), and be placed in a perspective

which matches the daily needs faced by IDUs. For example, education and outreach on HIV infection will be meaningless if it is delivered out of context of more pressing concerns often faced by IDUs such as homelessness, joblessness, mental illness, and inaccessibility of or long waiting lists for treatment facilities. Integrating HIV prevention into solutions for these immediate problems may well result in more permanent behavior change for these populations.

Such a solution to HIV prevention also requires support from traditionally non-HIV specific service agencies. Mental health and drug treatment programs and facilities must be expanded both to accommodate the growing demand for their primary services, as well as to incorporate HIV prevention messages into their service delivery regimes.

- **HIV Prevention Strategies Must Address Non-IDU Substance Use Issues as well as IDU Activity.**

As presented in the Behavioral Summary to the Epidemiologic Profile in Chapter One, initial research indicates that substance-using populations may be at high risk for HIV infection. For instance, one study showed that among gay men without primary partners, substance use variables were the most important in determining when these men engaged in unprotected anal intercourse. Sixty-seven percent of the men in this study reported always being high on alcohol or drugs when having anal sex without condoms. A similar correlation between substance use and risky sexual activity is found within the heterosexual community.

Many of the issues linking IDU activity with unsafe sex also apply to substance use and unsafe sex. Like programs designed to target IDUs, programs aimed at substance users must address not only how users engage in sex, but why and under what circumstances they do so.

In order to do so effectively, there is a need to establish HIV primary prevention programs within substance abuse treatment agencies. Like the proposed HIV prevention programs for IDUs, substance use programs which include condom distribution in conjunction with education, street outreach, and referrals for mental health and treatment will more closely meet the needs of substance users. And because substance abuse agencies are a point of entry and way of reaching individuals who may be at high risk for HIV infection, training staff in HIV prevention is critical. Interventions must be designed with the end result of helping users to develop skills for having and maintaining sober sex, since relapse of one type of behavior may mean relapse into another.

Because many substance users are not in treatment, and because substance use cuts across all demographic boundaries of age, gender, race, culture, and sexual orientation, innovative interventions which are culturally competent must be developed and evaluated. Surveys in STD clinics, schools, and primary care facilities have shown that the combination of alcohol and/or drugs with sexual activity is a common practice. All HIV prevention programs, regardless of the "target population" which they seek to serve, should explore the relationship between substance use and sex. Good interagency referral and coordination between HIV prevention programs and alcohol/drug prevention and treatment programs is therefore critical.

Finally, differentiation needs to be made between those populations for whom behavior can be modified by treatment, and those for whom behavior cannot be modified. This last group usually involves those so-called "dual diagnosed" individuals (i.e. mentally disabled, non-violent schizophrenics, non-paranoid schizophrenics, etc.) for whom maintaining consistent behavioral change is not possible. New strategies for preventing HIV infection of, and transmission by, these groups are necessary.

The preceding section illustrates as well the need for future research. Greater research needs to be conducted for populations who are not in treatment; in particular, homeless and mentally disabled populations. Studies of gay men in drug treatment programs should involve larger samples of minority populations. More information is needed on in-treatment and out-of-treatment youth populations. Alcohol and drug use questions should be included in future KABBs and needs assessments.

- **HIV Prevention Messages Must Reach Beyond Behavior Modification to Address Sociological and Psychological Issues Such as Self-Esteem and the Importance of Community Membership.**

Prevention strategies and interventions often focus exclusively upon altering behavior, and not upon altering the sociological and psychological influences which may cause that behavior.

Educational information about the causes and methods of HIV transmission will, in and of themselves, do little to change people's behavior. This fact has been most conclusively proved in the gay white male community, where, even though condom use and safe sex practices have increased, a high degree of unsafe sex

still occurs in a population which possesses a high level of knowledge about HIV transmission.[2]

Within this community, many researchers and social scientists posit that this barrier between knowledge and action, or between information and implementation, is in part caused by sociological and psychological pressures which discourage safe sexual practices. For instance, there already exists in the gay community a growing cultural division between HIV positive and HIV negative people. Focus group participants and providers alike report that the emergence of these two subcultures has created a sentiment within parts of each subculture that men are not really part of the gay community unless they are seropositive.

People at risk for HIV infection report other societal influences which inhibit prevention efforts. Many people believe that seroconversion is inevitable, and some believe that they will feel a sense of relief and stability once that line is crossed. This stability can be perceived as desirable when compared to the uncertainty and difficulty associated with remaining HIV negative.

Another perception within certain groups, perhaps borne out most fully in the gay white male community, is that the emphasis on the concept of "sex positive" has created an undesirable backlash. As seroconversions in the community increased dramatically in the mid-1980's, social scientists and prevention providers began seeing the development of a movement in which HIV positive men became seen as "guilty" for "spreading" the disease. In addition, as prevention efforts became intensified, sex itself began to be viewed by some as "wrong."

These sentiments gave rise to the "Sex Positive" concept, which encouraged sexual expression and activity as normal and healthy. Some providers and psychologists criticize what they view as the extrapolation of this idea to undesirable limits. Some Focus Group participants and key informant interviewees claim that this "Sex Positive" concept has evolved into the use of sexual activity as the barometer for acceptance or status in the gay community. Frequency of encounters and number of partners become the measures of social success. Sex takes on paramount importance, and non-sexual hobbies or means of socialization are devalued, and become unimportant. Others suggest that these norms existed before the "Sex Positive" campaign was undertaken.

Internalized homophobia and lack of self-esteem are problems which can exacerbate barriers to effective prevention interventions. One key informant

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[2]Please refer to Behavioral Summary, Chapter One, for specific KABB study references.

interviewee pointed to the gay newspapers as examples of community elements which help perpetrate this problem. He stated the belief that the papers focus almost exclusively upon negative issues: who is dying of AIDS, gay-bashing, challenges to civil rights, etc. In so doing, he believes the press makes it even more difficult for gay people to find reasons to maintain an upbeat perspective about life as a gay person. As he phrased it, "If all we're being told is that everyone in the world hates us, how are we supposed to believe that we have a reason to live, or that we shouldn't hate ourselves?"

Others report the feeling that San Francisco's HIV-affected communities are differentiated into dozens of social sub-groups, all of which are exclusionary and antagonistic to those which are different from themselves. This differentiation falls along racial, ethnic, gender, orientation, age, drug preference sub-group, geographic, and "style" (Bear bars, leather bars, sweater bars, dyke bars, lipstick bars) lines. Moreover, many people feel "forced" to choose membership in one group or another, with cross-over being discouraged. Stratification into so many sub-groups has, in the past, created a parallel structure within the prevention planning community, as interventions became increasingly tailored to the specific needs of narrowly defined sub-groups. A major unmet need, and a major challenge, facing today's prevention planners is to create an effective "mix" of strategies which target both global and specific needs, with the goal of providing a range of services which meet needs at every level in which they arise.

Self-esteem issues surface in different ways. Focus group participants from all demographic backgrounds report feelings of isolation from their communities. Many believe that their communities do not care if they remain healthy or not, and some believe that their communities actively want them to die. An often repeated request for fulfilling an unmet need is the desire for safe, clean, easily accessible gathering places like community centers, where people can meet to discuss issues, meet others like themselves, and gain peer validation and self-esteem.

In spite of these facts, many current and proposed interventions (particularly mass media campaigns) involve only the dissemination of basic transmission information. Advocates of these programs seem to ignore the fact that if societal barriers already serve to inhibit safer behavior among a relatively educated, socio-economically influential community like gay white men, these barriers will undoubtedly be even stronger within more marginalized communities.

For instance, in communities of color, even stronger cultural norms often exist which reinforce feelings of internalized homophobia, isolation, and low self-esteem. Latina women report that if they ask their partners to use condoms, this

simple expression of sexual sophistication may cause them to be viewed as "whores." Powerful taboos against homosexuality, in African American and Asian/Pacific Islander populations (and against all discussion of sexuality in Asian/Pacific Islander populations) create intense isolation for many gay men, and result in passive sexual activity in which they take cues for safe or unsafe behavior from their partners. Young men report the need to "belong" to a community, and the belief that seroconversion will increase their chances of being accepted by peers.[3]

One Asian/Pacific Islander youth focus group participant exemplified the intense sense of isolation, low self-esteem, and fear which can lead to unsafe behavior when he said, "I'm going to get my first HIV test results this week, and I don't know what they're going to be. In some ways, I hope that I'm positive. I'm not out to my parents yet, and if I tell them that I'm positive, I know that they'll take care of me and give me sympathy and support. If I'm negative and I come out to them, they'll just see me as gay, and they might throw me out or...I don't know what they'll do."

To be effective, then, HIV prevention programs must take into account the societal and psychological barriers which can serve to inhibit safe behavior. Simply handing out condoms or teaching about how transmission occurs, while important, cannot hope to significantly alter behavior, because it addresses only activity, and not the larger, underlying issues which cause that activity.

In order for this holistic need to be met, HIV prevention programs must, once again, be linked with non-HIV-specific services. To meet this need, prevention providers must develop coordinated, collaborative programs in conjunction with community leaders, churches and religious organizations, schools, and mental health providers to develop programs which simultaneously address both the cause and effect of high risk behavior.

- **Information on Prevention Services and Programs Must be Gathered in a Manner Which Enables Measurement of Unmet Needs.**

One of the most difficult issues in assessing unmet needs is that of accurate measurement of needs which are being met. This problem is heightened in a city like San Francisco where, because of the intensity and volume of AIDS-related research being conducted here, there exists a misperception that such information is readily available.

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[3]Information gathered from Focus Group participants from the following groups: Latina Women, Young African-American Men, Young Asian/Pacific Islander Men.

This sense of conviction that comprehensive analytical data regarding prevention services already exists has created an "Emperor's New Clothes" mentality which currently permeates all aspects of HIV prevention planning work. This perception first came to light as a result of the initial data-gathering for the Epidemiologic Profile. Many people, both researchers and community advocates alike, believed that the epidemiologic profile would be a simple matter of compiling existing data sources into a single document. Instead, the compilation of the profile became one of the most difficult and time-consuming aspects of the report, with much of the information being generated for the first time. The creation of the profile also highlighted the fact that for some populations -- transgender, homeless, and immigrants -- almost no primary data for San Francisco exists.

Similar concerns arose around the analysis of strategies and interventions. Information about what services are currently offered, and to whom they are targeted, is not compiled in any systematic or uniform fashion. The most comprehensive reporting data is that of annual and quarterly reports from the AIDS Office, but this information concentrates upon measurement of programmatic goals and objectives more than assessment of needs.

As demonstrated in Chapter Three, the lack of specific questions about clients served and client needs results in under- and over-counting, and skewed demographic data. For example, an analysis of the 1993 AIDS Office funded programs through quarterly and annual reports shows that not one program targeted gay white men as the primary service population. Although it is obvious that gay white men do receive prevention services which are government funded, the current mechanisms do not provide a system of reporting that accurately reflect this. Incomplete information may in part be responsible for the perception that gay white men as a group receive disproportionately greater services than others, even though no formal, reliable data exists to support this claim. For non-AIDS Office funded programs, statistical information is even sketchier.

This lack of uniform or mandatory reporting creates similar difficulties in the analysis of other key issues such as accurate measurement of prevalence or incidence data; definition of the particular technical assistance needs of provider agencies; definition of key areas for program linkages; etc.

A powerful barrier to changing the current information-gathering infrastructure is the common, deep-rooted assumption that permeates the HIV Prevention Planning community that comprehensive information does exist somewhere, somehow, and that it will turn up later if one looks hard enough. This misperception often makes people believe that resources are better spent in areas

other than data-gathering, particularly if they are convinced that the data already exists.

A great unmet need, then, is the creation of a uniform, mandatory system of data gathering and reporting, which will better enable prevention planners to assess the current system of prevention services in San Francisco. In many instances, the changes which are needed are minimal; in some cases, all it will take will be making some option reporting requirements mandatory, or adding a section to the quarterly reporting requirements. In other areas, such as non-government funded services, the change will require greater coordination with funders and grantmakers. Either way, the change is necessary not only to provide planners with better decision-making power, but also to help debunk the myth that planners are currently working with complete information.

Another problem with the current lack of uniformity in information-gathering is that it places into question not only inaccurate, but accurate information as well. Because it is difficult to separate which data are truly reflective of actual needs, and which are highlighting needs as a result of imperfect information, reliable information becomes perceived as being as speculative as truly incomplete data. Moreover, because data for certain populations in San Francisco are vastly more detailed than that for other populations, there is a pressure to discard or ignore more specific data until all data is at a level which enables comprehensive comparative studies. A primary need in San Francisco, then, is for planners and researchers to re-examine both the scope of data which is readily available, as well as the barriers to using this data which currently exist.

- **Services Must be Targeted at Who is At Highest Risk, and Perceptions of Service Decisions Must be Need-Based.**

This point, while growing directly out of the need for better information gathering as described above, requires additional emphasis. The cause-and-effect cycle with regard to information and targeted groups is most notable when political considerations become involved, and the undesirable end-product is the misallocation of resources away from those with the greatest need.

In the past, identification of priority populations and priority interventions was within the purview of State and Local Health Departments alone. There were often many factors that directly influenced these decisions. Unfortunately, those factors too often had no relevance to sound public health. This was in part due to rampant homophobia on the part of some administrators. The situation was further compounded due to incomplete information on various populations, particularly injection drug users, female partners of IDUs, and gay men of color.

These and other factors resulted in many populations at extreme risk for HIV infection being overlooked or ignored.

Today, prevention planners have the opportunity to learn from the experience of the past. Community Planning has changed the very framework in which decisions are made. There is now a partnership between infected individuals, affected communities, prevention providers, researchers, public health officials, and others. There is greater knowledge on populations at risk for HIV infection. By no means is there enough data on all populations, but planning is at a point where planners can begin to focus on the behaviors that place people at risk for HIV infection. Planners can begin to identify research priorities. They can tap the wisdom of providers and outreach workers. It is the culmination of these factors which will eventually lead to HIV prevention priorities being based upon sound public health policies -- where HIV prevention interventions are targeted at those at highest risk and with the greatest need.

Better information, then, will serve to protect not only those who are not recognized because of lack of information, but will also serve to protect those who are properly included because of their need, but whose needs are often devalued because of this same lack of data.

- **Transmission Information and Education Must be Delivered in A Clear, Concise, Consistent, and Culturally Appropriate Manner.**

All populations, regardless of risk, report a greater need for appropriately designed prevention education. While some of these needs can be met only through interventions tailored to very specific sub-group requirements, there are some overarching needs which cross over to all communities:

- Prevention providers must present uniform, unambiguous, non-contradictory data about safe and unsafe behavior. Prevention service clients report feeling overwhelmed by the amount of information which they get, much of what they perceive to be contradictory. This concern is most clearly illustrated in the messages regarding oral sex. People believe that they are receiving mixed messages not only about the risks of oral sex, but also about the relative differences in risk between different types of oral sex. When discussing oral sex risks, questions arise about whether statistics revolve around ejaculative or non-ejaculative oral sex, and differences between being the insertive or receptive partner. Similarly, among IDUs, while many expressed a high level of knowledge about needle-sharing and bleach, these same clients show highly disparate levels of sophistication about other transmission sources. In one focus group, the members concluded that HIV can be transmitted through sharing

cigarettes. Many clients express the belief that confusing data and different messages enhance the perception that practicing safer behavior is a difficult, costly, and ultimately uncertain process.

- Change must be targeted at both group and individual norms. Clients from all communities express the difficulty of taking responsibility for changing individual behavior, particularly if the wider peer, cultural, and social groups within which the individual moves are not receptive to that behavior change. For instance, gay men report how difficult it is to consistently practice safer sex in an environment which often measures acceptance by sexual activity. In order for strategies targeting individual change to be effective, those strategies must be developed in conjunction with larger community-change oriented interventions which have the same message, goals, and means of achieving the desired outcomes.

- Whenever possible, prevention messages and education must be delivered by community peers. Once again, clients from all communities report that, in HIV prevention, the messenger is as important as the message itself. People inherently place greater trust in messages delivered by people who look like them, act like them, live where they live, and speak their language. Many people also report being powerfully affected by HIV prevention messages delivered by HIV positive peers. The ability to self-identify with a person, to be able to say, "This could be me," is, for many, the strongest prevention message available.

III. IDENTIFICATION OF HIGHEST RISK COMMUNITIES AND TARGET POPULATIONS

> *"I'm dating a white man, and my brothers and sisters have a difficult time dealing with that. They criticize me, they're real critical to me, and I try to just brush it off, but it's hard to brush it off, because, I mean, these are the people you see every day. These are the people that you are always around. So I try to go to the white community with my friend, thinking that things will be much better there, but it's even worse, so I find myself being excluded from the gay community and just staying at home. And that's really bad, because I want to get out and do things like they're doing, without being looked down on, as some sort of bizarre outcast. 'Cause I mean, I'm just the same as everybody else."*
>
> *-- Young African American Gay Man.*

Identification of highest risk communities and target populations is somewhat similar to peeling an onion: identifying and removing the outer layers is a fairly simple process, but as one gets closer to the center, distinctions start to blur, and the different pieces cease to separate into clearly definable parts.

For instance, the Epidemiologic Profile suggests that, even without the benefit of the Priority Criteria model, young men of color who have sex with other men are, as a group, at substantially higher risk of HIV infection than Caucasian women who only have sex with other women.

At the other extreme, even with the benefit of the Priority Setting Criteria model and all of the focus group and key informant information, it is extremely difficult to prioritize whether African American IDU men are at higher risk than homeless immigrant Asian youth. Comprehensive data are simply not available for that degree of specificity.

And while San Francisco's data is far from being complete, the Epidemiologic Profile which has been compiled expressly for this planning process is still the most extensive and comprehensive data available in the country. Thus, in light of the available data, some clearly defined High Risk Target Populations do emerge.

As explained in Chapter Four, the Priority Setting Criteria look to behavior and transmission activity (i.e. blood to blood, semen to blood, vaginal secretions to blood) in order to identify target populations. When these behavioral characteristics are applied to the demographic data contained in the Epidemiologic Profile (i.e. prevalence and incidence projections by population),

the following groups emerge as those with the highest risk of HIV infection, and therefore constitute San Francisco's "Target Populations" [4] (***important note: the following target populations are not listed in any particular order of priority or ranking of need):

- Injection Drug Users
- Gay Men, including men who have sex with men but do not self-identify as being gay, gay sex workers, and men who engage in bisexual behavior (usually with gay or bisexual men).
- Youth identified as Runaway, Homeless, IDU, Sex Workers, Out of School, and Gay. (This group also includes gay and bisexual youth and young adults, particularly young people of color, including youth who do not self-identify as being gay, but who engage in sex with people of the same gender.)
- Women who practice Substance Abuse, those with multiple sex partners, sex workers, those who are partners of IDUs, and those who engage in bisexual behavior.
- Transgendered people
- Homeless adults, including those in shelters.
- Immigrants
- Incarcerated people

The body of this section will address each of these groups in turn. Where appropriate, particular emphasis will be paid to the prevention needs faced by people of color, as epidemiologic data always shows these populations to be at higher risk within each group categorization.[5]

In reading this section, it is important to keep in mind two key considerations: 1) No further presentation or analysis of epidemiologic data is to be undertaken in this section. A thorough analysis and behavioral summary of each of these populations is presented in depth in the Epidemiologic Profile. Therefore, it is critical that the Epidemiologic Profile be read first before turning to this section. 2) A major focus of this report is the importance of looking to overarching themes regarding behavior and transmission, rather than to "status" issues such as race, ethnicity, and gender. Because target populations necessarily break down more along "status" lines than behavioral lines, the needs which arise may not be indigenous to only one group or another. In fact, the opposite is usually more accurate: truly critical needs usually apply to multiple target populations.

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[4]The target populations listed here do not include hemophiliacs. The issues of hemophilia and blood products were originally voted to not be included by the Planning Council. The later decision to include hemophilia was not made until the September 21, 1994 council meeting, and as such, that section is unavailable for the October 3, 1994 draft document.

[5]Please refer to Epidemiologic Profile in Chapter One for detailed statistical data comparing HIV prevalence between ethnic groups within each risk category.

For this reason, the greatest unmet needs have been presented in the preceding chapter. What follows under each target population heading, then, is the following:

a) a more detailed examination of how overarching needs specifically apply to each of these groups, and
b) needs which may be indigenous to a particular group.

These needs will in turn be compared with the current range and effectiveness of strategies and interventions currently being employed in San Francisco, as depicted in the Resource Inventory and Strategies and Interventions chapters.

The discussion of needs will incorporate the following material:
1) Are there current programs which specifically address the target population?
2) Are these programs effective?
3) If not, are there other current programs which adequately meet the needs of the target population?
4) If not, what are these unmet needs?

A further note regarding the description of target populations in this section: Because this plan is intended to be viewed in its entirety, with each chapter providing critical elements to the overall structure, certain important information concerning a specific target population's needs may be explored in depth in other chapters. When this occurs, the reader will be directed to that section of the report, and only the most pertinent information will be included here, to avoid unnecessary duplication and use of space.

On a practical matter, the cumulative effect is that for this chapter, those groups which have almost no demographic or other statistical information available receive the most in-depth treatment here. This is the only forum in this report through which those needs can be explored in greater depth. Therefore, the sections which follow on Gay Men, IDUs, Women, and Youth are shorter than those for Immigrants, Transgendered People, Incarcerated, and Homeless Adults. The relative length or depth of treatment is in no way reflective of the priorities being placed on these groups; it is simply an indication of whether or not those groups are comprehensively examined elsewhere in the report.

Injection Drug Users

> *"I don't blame it on anybody except myself. 'Cause I'm the one who stuck the needle in my arm. Not my mother, not nobody else but me. But, at the same time, my self-esteem was so bad that I didn't give a fuck about*

nobody. I didn't care about my mother, my newborn child, my wife, everything, and I had it made, too, you know?"
-- Latino IDU Man.

There is an estimated population of between 13,000 and 16,000 injection drug users in San Francisco. As such, IDUs account for 2.5% of the total population in San Francisco. Of these people, only about twenty-five percent are currently engaged in some sort of treatment or rehabilitation program. It is estimated that about 21-22% of the IDUs in San Francisco are HIV infected.

As one example of HIV infection statistics among the IDU population, HIV seroprevalence results obtained from the 150 HIV Counseling and Testing Program sites show that for first time testers during the period of January 1993 through May 1994, of 593 self-identified IDUs, 99 tested positive, for an overall rate of 16.7%. IDU men who have sex with other men showed the highest seroprevalence rate, with 73 of the 193 men testing positive, for a 37.8% conversion rate. At the other end of the scale, none of the 5 IDU women who report exclusively lesbian activity tested positive. For a more detailed depiction of IDU HIV seroprevalence statistics, please refer to the epidemiologic profile in Chapter One.

A critical issue with the IDU population in San Francisco is that of the multiple avenues and opportunities available for HIV infection, both from sexual activity as well as injection drug and other substance use. In addition to the risk of infection through needle sharing, there is a high correlation between IDU activity and the prevalence of unsafe sexual activity. For instance, among female IDUs, unprotected sex with men appears to be the principle risk factor for HIV infection. Similarly, among <u>non</u>-injecting women partners of male IDUs, the Carbo/Wolitski/Tanner study found that 95% of these women reported unprotected vaginal sex in a six-month period.

As with all populations, IDU people of color are impacted to a greater extent than their white counterparts. For instance, as depicted in Chapter One, the Urban Health Study Street Based Study of female IDUs found that African American women were 4.5 times more likely, and Latinas were 3.9% more likely, than White women to be infected with HIV. The same study found that African American IDU men who have sex with women were 3.4 times more likely than others to seroconvert. Similarly, in the AMEN multi-ethnic neighborhood study, African American gay/bisexual IDU men showed higher conversion rates than other groups.

Within the IDU population, then, the overall trends for risk factors mirror the larger communities as a whole, except that the "baseline" prevalence rates are

simply higher across the board. For example, like their non-IDU counterparts, men who have sex with men are at higher risk than men who have sex with women, and women who have sex with women show lower risk than all other groups. People of color within each of these groups are at higher risk than white people. But within each group, IDU prevalence is substantially higher than that for non-IDUs. For instance, IDU men who have sex with women show more than double the prevalence for HIV infection than non-IDU men who have sex with women.

Behavioral data for IDUs falls into two primary categories: that which focuses primarily on IDU activity itself, and that which addresses sexual activity and other modes of non-IDU transmission.

Taken as a whole, IDUs are a population which demonstrates that behavioral interventions aimed primarily at IDU activity are effective. Strategies targeted at altering needle sharing practices (i.e. needle exchange programs, street outreach, and counseling and testing) have had a significant impact on needle use behaviors. Strategies aimed at changing non-IDU transmission behavior have not been as successful. In particular, IDUs show a particularly high prevalence of risky sexual behavior.

Another area of particular relevance to IDUs as a whole is that of attitude. In focus groups, IDUs expressed heightened fear of contracting HIV through drug use. This fear may account in part for the efficacy of strategies targeting changes in IDU-related behavior as opposed to sexual activity. Basic knowledge about other routes of HIV transmission is uneven. Members of a Latino IDU focus group agreed that HIV could be transmitted by sharing cigarettes. Another common perception of IDUs is that although most do not regularly share needles, they have done so in the past, and expect that they will inevitably need to do so in the future.

IDUs also show a keen understanding that their own behavior varies greatly depending upon how their drug use impairs decision-making. As expected, highest risk activity takes place when IDUs are most in need of drugs, and this activity can take place either in the form of sharing needles, having unprotected sex while under the influence of drugs, or engaging in sex in order to get drugs or money for drugs. Said one IDU focus group participant, *"Once you get a hit and you run out of money, you ain't got no time to worry about no condom. Only thing you worried about is the next car to fly by, or the next person to fly by, or whatever you have to do, you gonna do it! And you might think about a condom, 'Oh, maybe I should use a condom,' after that, but once you get that ten or twenty dollars and you go back down the street and get you a hit, you ain't got time to think about no condom, the*

only thing you got time about is get to your destination, and get you a hit. After that's finished, you go and take care of your business again!"

A primary need for prevention messages targeting IDUs, then, is for policies and programs which look to the overall context in which IDUs take drugs, engage in sex, and the causal links between the two activities.

Finally, as in other groups, IDUs are uncertain about accessibility and availability of services. While some people are aware of specific programs and community-based organizations targeting IDUs, many are unaware of how or where to get help. This uncertainty pertains both to specific HIV prevention services, as well as to non-HIV-specific drug treatment and rehabilitation programs, such as methadone clinics.

Drawing upon the variety of epidemiologic, behavioral, demographic, and qualitative focus group and survey data presented in previous chapters, and summarized here, the specific HIV prevention needs for IDU populations can be categorized as follows:

1) Specific interventions aimed at changing unsafe needle use practices.
2) Specific interventions aimed at changing unsafe sexual activity.
3) Outreach and referral services for drug treatment and rehabilitation options.
4) Mental health counseling and outreach.
5) Outreach and referral services for non-IDU substance use.

Once again, for each of these needs, particular focus needs to be paid towards programs that target people of color, as these groups uniformly show higher risk of contracting HIV in all situations.

Efficacy of Current Strategies and Interventions Targeting Needs of IDUs

As illustrated in Chapter Three, needle exchange programs appear to be the most successful of all strategies targeting HIV prevention. The Watters/Estilo/Clark study showed that client contacts in San Francisco needle exchange programs increased steadily from implementation in late 1988 to a peak of 16,000 client contacts during a six-month period in 1992. The ratio of needles exchanged increased from two per client to 21 per client during that period. All studies show that individuals who engage in needle exchange have a strong correlation with a decrease in needle sharing injection drug activity.

Training in bleach use is another generally successful intervention. Like needle-exchange programs, bleach use is most effective when the behavior modification

can be incorporated into daily activities in a realistic and easily adaptable manner.

Because only 15-25% of IDUs are in treatment, street-based interventions are imperative. This premise is born out by an analysis of 1992-93 AIDS Office data, which shows that IDU-targeted programs that included large outreach components often achieved or exceeded goals, while non-outreach based programs (such as walk-in clinics) were not as successful at meeting goals.

Data also shows that differences in drug preference sub-groups are directly related to the efficacy of interventions. For instance, cocaine injectors as a group engage in higher risk sexual and needle sharing behaviors. Crack smoking IDUs are more likely to report high risk behavior such as exchanging sex for money or drugs, multiple partners, or injection in shooting galleries. And because drug preference sub-groups often match cultural or ethnic populations (i.e. African American women are more likely to be injection cocaine users, and this sub-group shows a correlation to high HIV risk behavior and prevalence), identification of strategies targeting these particularly high risk groups is a critical unmet need.

Statistical data for IDUs is currently gathered along sexual orientation categories (i.e. men who have sex with men, women who have sex with men, etc.). While this is helpful in making comparisons with other high-risk groups who are at risk primarily because of sexual behavior, these classifications are not necessarily the best means of classifying IDU behavior. In fact, as a group, IDUs are the only population, regardless of risk, who are exposed to a high risk of transmission through non-sexual behavior.

For these reasons, there is a strong need to classify IDU behavior by drug preference sub-groups, and then to examine these populations for ethnic, racial, and gender demographics. This information is essential to the development of effective prevention messages and outreach efforts, because it enables service providers to specifically target messages to discreet populations.

Data regarding specific mental health and psycho-social needs for IDU populations is highly qualitative and speculative at best. Drawn primarily from focus group and survey data, the information shows that IDUs need to find realistic avenues through which to confront their fears of HIV infection which, for many, evolve into a sense that infection is inevitable, and therefore preventative measures serve only to delay a predestined future.

Unmet Needs

The highest unmet need among IDU populations in San Francisco is designing culturally appropriate programs specifically targeting risky sexual activity. "Culture" in this context encompasses the concepts of those activities or normative values which bring people together, and can be based upon race, ethnicity, gender, age, sexual orientation, and behavior (i.e. drug preference sub-cultures). Current programs are effective in altering risky needle-sharing use, and several programs, both private and government-funded, are in operation to meet this need.

However, programs aimed at altering sexual behavior have not been as successful primarily because of their failure to take into account the correlation for IDUs between sexual activity and drug use. These programs tend to treat sexual activity and drug use as unrelated issues, and in this way fail to address how IDUs are most at risk for transmission. This need is perhaps best illustrated by this comment from a Transgender focus group participant, who identified as an IDU: "When *you're out there, and you're on the stroll, and you're homeless, or you're an addict, you're gonna do whatever you need to do, to get that next hit, or get that roof over your head, for that night...I've been there, I know. I been strung out on crack, and I didn't give a fuck if I had to suck on a dirty dick in Macy's window on a Monday morning, I was gonna do it. And I didn't care if you put a rubber on it or not.*"

Programs targeting IDUs need to address the fact that for many IDUs, sexual behavior and activity is intricately woven into their IDU status, and that in order to effectively achieve prevention goals, that symbiotic relationship must be taken into account. This fact may also be partly responsible for the relative success of drug-use oriented programs versus programs targeting sexual activity. Several IDU focus group participants pointed out that the particular inter-relations between drugs and sex creates situations in which the need for drugs or the use of drugs can often contribute to unsafe sexual practices, but unsafe sex rarely results in the need for drugs or unsafe needle use. This may also account in part for the greater efficacy of needle exchange or bleach programs which do not take into account sexual behavior, but the much lower success rate of programs intended to alter sexual practices which do not expressly target IDUs.

With regard to needle exchange and bleach programs, these programs need, at a minimum, to be maintained at their current levels. The focus of these programs must shift even more to culturally and geographically appropriate outreach and street level interventions, and move away from center or clinic-based operations which require clients to come to the service provider. Information also needs to be gathered about how best to disseminate information or to get potential clients interested in exploring service options. Finally, needle exchange and bleach

programs need to present a single, clear, consistent, easily understood and implemented message about the protocols for cleaning works.

For instance, in a focus group of African American women from the Bayview/ Hunter's Point area, almost nothing was known about the PHREDA project, even though this is a project with over a million dollar budget, located in Bayview/ Hunter's Point, and specifically targeting African American women. Many of the focus group participants felt that their lack of knowledge about the program stemmed from the fact that the project had not been introduced to their community in an appropriate manner. As an example of what they thought would be effective, these same women proposed informal "fish fries" or discussion groups sponsored by prevention providers in the women's neighborhoods, at which people could socialize, eat, and discuss prevention issues immediately relevant to their daily lives with other people who faced the same daily concerns and pressures.

This need for information highlights the fact that, with the expansion of the breadth of outreach services, must come the expansion of the scope of these services as well. Outreach workers must be able to make referrals about treatment options and programs and mental health services in addition to providing resources for needle sharing and bleach education.

Further research is another need that must be met if effective strategies are to be developed that meet the particular needs of IDUs. In addition to the calls for specific types of research outlined in Chapter Three, there also needs to be greater data collection about the specific needs inherent to different drug sub-groups. And because these groups often correlate to particular geographic or ethnic sub-groups, this data will help clarify barriers that exist in transferring the successes of interventions for one group to the current problems faced by another.

The behavioral summary in Chapter One makes recommendations for future research which will help gather the statistical data needed to start answering some of these important questions.

Gay Men

Gay Men (including all men who have sex with other men) continue to comprise the transmission group with the highest prevalence of HIV in San Francisco. Out

of the 28,000 estimated men, women, and children living with HIV in San Francisco in 1992, approximately 25,000 were gay men.[6]

Racial and ethnic demographics as depicted in the Epidemiologic Profile show that IDU gay men have a higher HIV prevalence than non-IDU gay men, regardless of race or ethnicity. African American and Native American gay men show the highest seroprevalence along race/ethnicity lines. Latino/Hispanic and White men show the next highest seroprevalence, and Asian/Pacific Islander gay men show, as a group, the lowest seroprevalence. More detailed statistical breakdowns are available in Chapter One.

Several conclusions can be drawn about the needs of gay men as a group, regardless of race, class, language, or ethnicity. Since the beginning of the HIV/AIDS epidemic in 1981, gay men have made remarkable changes to their risk behaviors. They were the first focus of attention when the epidemic began, and were the first targeted groups for HIV prevention programs. Studies of the responses of self-identified gay men to the AIDS epidemic have documented some of the most profound reductions in risk behavior ever recorded. Gay men have been perceived as so successful at adopting new behaviors that it is tempting to view them as a model population, with little need for further intervention regarding risk-reduction strategies.

Public policy based upon such perceptions would be viewed by many service providers as a disastrous result. These providers believe that the intrinsic connections between sexual behavior, identity and ego formation, intimacy needs, and the construction of community norms have always combined to make sexuality a basic and powerful drive. Modifying and maintaining sexual behavior in a time of loss and in the midst of an epidemic necessitates continual, renewed, and innovative strategies of public education and support, particularly in communities which are suffering nearly unimaginable loss and despair.

Many gay men have adopted significant behavior changes as a result of effective public health education. For many gay men, it is episodic relapses into unsafe forms of sexual behavior, and not an overall refusal to adapt behavior, which need to be the primary target of HIV prevention interventions. As demonstrated in the behavioral summaries of Chapter One, this is particularly the case for middle class white men above thirty. Such "slips" within a population which has such a high concentration of HIV infection suggests a far greater risk for HIV transmission that for a comparable act in populations with low HIV seroprevalence.

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[6]HIV Incidence and Prevalence in San Francisco in 1992; Summary Report from an HIV Consensus Meeting. February 12, 1992.

Studies also demonstrate the high correlation between issues of self-esteem and community, and risky behavior. Several studies have shown that high-risk taking does not occur randomly, but instead is triggered in specific situations where sociological or psychological issues come into play. For instance, these studies indicate that gay men with low self-esteem are less likely to assert themselves in situations where unsafe sex is likely to occur.

For men less acculturated within systems of "gay community," particularly men of color and younger gay men whose understanding and practice of sexuality are still emerging, the need for culturally appropriate basic HIV education prevention programs persists.

Assessing the needs, then, both met and unmet, for gay men as a group is a daunting prospect. On one hand, because the seroprevalence for this group is so high, there has been more primary data gathering and research conducted on this population than for any other risk group. On the other hand, because of the sheer size of the population, studies have often concentrated upon very specific subsets of the overall group. Such studies, conducted with vastly differing methodologies and objectives, are difficult to analyze in a manner that consistently elucidates measurable needs.

Evaluation of the needs, and whether or not they are being met, is equally problematic. As shown in Chapter Two, reporting requirements for prevention agencies makes accurate data analysis difficult. For instance, even though gay white men constitute more than 40% of the HIV infected population in the city, an analysis of the AIDS Office reporting summaries for 1992 would leave the reader with the impression that not one Department of Public Health-funded program in the city targeted gay white men.

While this information is clearly erroneous, it also unveils an important issue surrounding the needs of gay men. Many providers and clients alike perceive that gay white men, as a group, receive a disproportionate amount of public funding for HIV prevention and services. This perception has, in turn created, in the perspective of several interviewees, a political backlash against provision of services to gay white men. In fact, the available data seems to contradict perceptions of disproportionate government funding to prevention efforts targeting gay white men. However, until a uniform data collection and reporting mechanism is developed (as outlined in Chapter Two), the gaps in information will continue to fuel this suspicion, and affect prioritization and funding issues. Any such decisions which impact upon so large a percentage of the afflicted population must not be taken lightly.

Gay men of color, particularly African American, Latino, Asian, and Native American men, have discreet prevention needs which often go unmet by organizations targeting a wider audience. In Chapter One, epidemiologic data and a summary of behavioral studies describe the impact of inadequate prevention efforts targeting these men. Gaps in information previously addressed illustrate that even these descriptions may fall short of fully capturing the magnitude of public health challenges in this area.

In addition to those challenges faced by gay white men, gay men of color face unique obstacles to the adoption and maintenance of safer sexual behaviors. Cultural and ethnic taboos against homosexuality are a primary barrier, as are difficulties in language access. For instance, in one study of gay African American men, prevention strategies which targeted only homosexual identification, and not homosexual behavior, were ineffective in reaching the target group.

Racism in the larger community, as well as European American dominance in the "gay community," present obstacles for many gay men of color to identifying with the very concept of "gay community," and implicitly challenge the notion that messages tailored to a large self-identified gay audience will in any way affect behavior changes in large numbers of gay men of color.

Additionally, among gay youth, prevention strategies targeted at the "gay community" may be ineffective, since many gay youth primarily identify with the "queer community" rather than the "gay community."

Unmet Needs

An analysis of the met and unmet needs of gay men is difficult to categorize for the myriad of reasons mentioned above: large size of population, stratification and differentiation into a vast array of discrete sub-cultures, and the deeply-held myths and misperceptions about service provision attached to each of these cultures.

As a broad categorization, the unmet needs of gay men revolve not around number or range of services, but upon the focus of service delivery. Services now need to expand beyond education which merely encourages behavior change, to include strategies which assist maintenance of behavior change. Prevention programs targeting gay men have in the past focused primarily upon specific identities, and by so doing been lost on men who for many reasons do not self-identify as gay. Successful programming, particularly that which targets gay youth and men of color, will need to address this differentiation of identity,

and focus upon sexual behavior and sexual identity within these cultural and developmental contexts.

As the gay male sub-groups become more and more distinct and autonomous, strategies and interventions need to become more culturally and linguistically appropriate, and accessed through peers. Each of these unmet needs is addressed in greater detail in the paragraphs which follow.

Although HIV/AIDS prevention programs targeted to acculturated, middle class, gay men have been largely successful, it is a mistake to believe this population does not require further intervention. Behavior change maintenance may become the critical issue in developing a new generation of HIV/AIDS prevention programs for this population. These programs will require focusing on psychosocial issues, as well as the skill building and communication/ negotiation curriculums which have been the hallmark of programs in the past. Understanding the context within which gay men view their sexuality and the meaning it has on various aspects of their lives, as well as at different points in their lives, will be a critical issue to explore in designing newer programs. Also, for self-identified gay men who have experienced repeated loss in their personal lives due to the epidemic, it will be important to examine the impact this has on perceptions of risk and self-worth. (For a more detailed discussion on sociological and mental health issues, please refer to the section on overarching themes, presented earlier in this chapter.)

For men who have sex with men but do not self-identify as gay, prevention programs will have to become centered on messages about specific behaviors rather than sexual identities. Appealing to gay men exclusively, regardless of self-identification, has resulted in misperceptions about the virus and how it is transmitted.

Overall, developing prevention programs for gay men has increasingly become more complex as the epidemic and certain populations age, as large numbers of young people acknowledge the centrality of their gay sexuality at increasingly early ages, and as more men of color -- particularly young men of color -- become disproportionately represented in the tracking of new AIDS cases. Simple, one-shot campaigns, couched in simplistic terms such as "On me, not in me" are no longer effective in reaching the diverse population of gay and bisexual men who live in San Francisco.

Sexual identification, age, culture, and values all impact on how messages are both transmitted and received, and these variables must be considered in the design of all prevention programs that target the large population of men who have sex with men.

Youth

Only in recent years have prevention efforts begun to focus on youth as a distinct risk group. The importance of working with youth as a group is two-fold. Given the estimated ten year incubation of the virus, most of the 20-30 year olds with AIDS became infected with HIV as youth. Moreover, the developmental stages of adolescence and early adulthood involve experimentation with different behaviors and attitudes which place youth at risk. Indeed, because adolescence is commonly the period during which sexual behavior is initiated, prioritization of culturally appropriate youth prevention efforts is an opportunity to assist in the formation of healthier sexual habits at the onset of sexual maturity.

Increasingly, evidence suggests that among youth as a whole, there are sub-groups of youth who are at much greater risk and who require targeted prevention efforts. An immediate need in San Francisco is for reliable data-gathering from these sub-groups, such as incarcerated youth or youth involved in the juvenile justice system.

The youth population as a whole is estimated to have a 3.5% HIV prevalence rate. In significant sub-groups of youth, exclusively heterosexual and non-injection drug using, available evidence suggests that the prevalence is very low. However, among other subgroups of youth the prevalence is extreme. Young IDU women and young gay men show nearly 10% and 40% HIV prevalence rates respectively. Young IDU gay men show a prevalence of over 50%. Based on behavioral studies, homeless, runaway and incarcerated youth are also all at significantly increased risk.

Young gay and bisexual men are among the highest risk groups in the city. High-risk behaviors, particularly unprotected anal intercourse, continue to be endemic among gay men during adolescence and young adulthood. Without dramatic and effective intervention, gay and bisexual youth and young adults face the prospect of seroconversion rates mirroring those faced by gay and bisexual men in the early years of the epidemic.

Race appears to be a particular co-factor of risk. Recent studies demonstrate that gay/bisexual men of color, particularly African American and Latino young men, engage in disproportionately high levels of high-risk behavior. Consequently, the seroprevalence among young gay men of color is almost double that of young gay white men.[7] Much that has been said about differentiation of culture among gay men holds true for young people as well, and the implications for prevention programming are the same. In addition,

[7]For actual epidemiologic data on these groups, please refer to the Epidemiologic Profile in Chapter One.

youth programming will need to take into account the impact that racism and Eurocentrism within the gay and larger communities have on young people's self-esteem and sense of self-efficacy to insure the capacity to develop and maintain safe behavior.

One study of young gay and bisexual men found that the number of sexual partners, number of receptive anal intercourse partners, injection drug use, age and race were significant predictors of seropositivity. Of particular interest in this study was the finding that knowing their primary partner's HIV status did not appear to be a factor in reducing high risk sexual behaviors. This may be explained by the finding that the strongest barrier to practicing safe sex among this particular sample may exist in close relationships (i.e. repeated sexual intercourse with the same person or persons over an extended period of time), where issues of intimacy, trust, and sharing risk work against safe behaviors. In San Francisco, rates of STDs are significantly higher for adolescents than adults. The sexual risk behaviors are similar to those that put them at risk for HIV infection.

The San Francisco Homeless and Runaway Youth Network estimates that there are 2,000 homeless and runaway youth in San Francisco. All of the experiences and factors that put in-school youth at risk for HIV infection are more profound for youth who live on the streets, in shelters, hotels, or in squats. Added dimensions of physical and sexual abuse, financial difficulty, and social, physical and psychological isolation make street youth an important population for HIV prevention.

Unmet Needs and Recommendations for Prevention

A growing group of agencies is working to prevent the spread of HIV among youth in San Francisco. These include the Wedge Program, Asian AIDS Project, Asian American Communities Against AIDS, the California AIDS Intervention Training Center, Instituto Familiar de la Raza, Bayview Hunter's Point Foundation AIDS Prevention Outreach, LYRIC, Special Programs for Youth, and Q Action. Other programs not funded by DPH include Larkin Street Youth Center, Cole Street Clinic, Mission Neighborhood Health Center: Latino Youth Prevention Case Management Program, and the Real Alternatives Program. (See Chapter 3 for more detail on current programs).

Still, youth advocates point to the need for increased services and research. The need for services targeting young gay men of color is acute, and these services need to be presented in a range of community settings which recognize the overlapping natures of race and sexuality. A significant finding of the Young

Gay Men's Health Study is that unsafe sex typically occurs within one's own home or one's partner's home. Contrasting the popular myth that bathhouses and sex clubs foster unsafe behavior, this finding suggests the need for prevention messages that are personalized to type of relationship (in this study 44% of the sample reported a steady partner vs. 28% reporting a casual partner) and again, to issues of trust and intimacy.

It has not been a common finding that younger gay and bisexual men are unaware of behaviors that place them at risk for infection. Targeted prevention programs must begin to address changing peer norms for safe sex, providing HIV counseling and testing services for this specific population, and the psychosocial and developmental needs of young gay and bisexual men, including: support and counseling to address issues of abuse and forced sex; assistance in the development of communication/negotiation skills; programs to address substance abuse; and programs which address the impact of racism and homophobia on the development of self-esteem and self-efficacy among young people.

In addition, research focused on HIV prevention strategies within communities of color and the effects of culture, values, and beliefs across cultural boundaries must be thoroughly explored for the design and implementation of effective prevention programs for young and bisexual men of color. For example, studies consistently portray African American youth with the highest rates of seroconversion among young gay and bisexual men. However, there is little understanding of the factors and determinants responsible for this serious trend.

Early onset of sexual activity, multiple partners among those who are sexually active, and the percentage of both youths and adults engaging in unprotected sex with youth partners also place in-school youth at risk for HIV infection. In-school youth need more skills-based training in communication and negotiation as well as social skills to resist negative peer influences. Cultural differences in sexual communication skills should not be overlooked when developing such interventions. More initial intervention time may need to be devoted to overcoming cultural barriers against discussion of HIV and sexual behaviors when working with immigrant students. Peer-assisted behavioral interventions might lead more readily to the adoption of HIV-preventive social skills.

Although large scale surveys are important, they have limited data regarding sexual practices, especially for gay, lesbian or bisexual youth. To understand the behavioral risk of students, it is necessary to ask more detailed sexual behavior and drug use questions. Questions about homosexuality should be included on all surveys. When such questions are not asked, youth who have had sex with someone of the same sex may feel there is something wrong with them and may

be reluctant to talk about such behaviors in the future. This can only hamper HIV prevention efforts.

Youth should be involved in the development of focus groups, surveys and interviews in an effort to assist researchers in asking questions that are more youth specific. The development of variables should include a process for standardizing important behavioral variables and related constructs. To date, lack of standardized measures for assessing some of these variables and constructs make cross-study comparisons difficult.

HIV prevention for homeless and runaway youth can not take place in isolation of other social problems that street youth face. Involvement of more youth in the development, implementation and evaluation of prevention efforts will lead to more appropriate programs for this population.

HIV prevention programs should be funded in temporary shelters, food service agencies and other agencies that homeless youth may use (health clinics, drug treatment programs, STD/family planning clinics, shelters, and community youth programs). Staff at the aforementioned agencies should be trained for appropriate counseling and referral. Although these agencies and programs may be important venues for reaching homeless and runaway youth, outreach to youth who are not accessing the system should be made. Needle exchange and condom distribution should be made readily available to homeless youth.

Women

Women comprise just over 50% of San Francisco's estimated 638,900 population size. As depicted in Chapter One, women as a group are thought to account for approximately 4.1% of the total distribution of HIV infection in the city.

As indicated by the Epidemiologic Profile, published studies do not provide detailed race/ethnicity breakdowns for HIV infection among women. Available information does allow for certain demographic estimates. Like in all other target populations, IDUs show the highest HIV prevalence, regardless of race or ethnicity. Among IDU women, those who have sex with men show a higher prevalence than those who have sex exclusively with women.

As an overall group, African American women have the highest seroprevalence rate. White women come next, followed by Latina/Hispanic Women. Asian/Pacific Islander women show the lowest seroprevalence. Studies for Native American women are too limited to make accurate seroprevalence

predictions at this time. (More detailed epidemiologic breakdowns for each of these groups is available in Chapter One.)

When demographic, prevalence, and incidence data are examined in conjunction with behavioral and other priority-setting criteria, certain patterns begin to emerge. Reference should be made to the Epidemiologic Profile for a detailed discussion of the specific prevalence, incidence, surrogate marker, and other data surrounding HIV infection in women. What is illustrated below are the highlights of needs identification in women.

The highest need that emerges from the latest seroprevalence and risk behavior research is the high numbers of women reporting unprotected sex with gay and bisexual men and drug users. These women uniformly show the greatest risk of HIV infection, regardless of race or ethnicity. Statistics also show a very high correlation between women who engage in this type of behavior and IDU use of their own. As indicated throughout this report, one of the immediate needs which this data reveals is that of specific, sub-group oriented research. For instance, in seeking means to change behavior, more information must be gathered on how much unprotected sex among women is the enforced result of working in the sex industry, or what is known as prostitution survival sex.

A study by the San Francisco Department of Public Health recently found, however, that 22% of self-identified lesbian women reported having sex with both men and women in the past three years, and 3% reported exclusively heterosexual activity during that period. 12% of lesbian and bisexual women reported sex with an IDU woman, and 5% with an IDU man, during that same period. This data shows a two-fold need surrounding lesbians. First is the need to gather data which specifically targets lesbian behavior, because current information-gathering methods do not address this area. Secondly, programs and services targeting lesbian women need to address the fact that many self-identified lesbians are engaging both in extreme low-risk behavior such as lesbian sexual activity, as well as extremely high-risk behavior such as heterosexual sex with gay and bisexual men, or IDU behavior.

For heterosexual women, IDU use is again the highest risk of transmission. For non-IDU women, based only on existing studies, African American and Hispanic women report the greatest barriers to using condoms. Issues which prevent condom use include power imbalances in the sexual relationship, economic incentives for women engaged in sex work not to use condoms, cultural norms which equate condom use with promiscuity, and conservative societal norms about the role of condoms as reducing the sense of intimacy, trust, and pleasure associated with sexual activity.

Prevention efforts tailored to women need to address the societal, legal, and cultural norms which inhibit use of condoms. Educational efforts which stress men's responsibility for using condoms and which help women to develop negotiation skills for their use are one core method of achieving this. In addition, strategies which convince both men and women that they are at risk, even when in a primary relationship, are needed to counter the common misperception among heterosexuals that only gay people are at risk.

Because women of color must often deal with particularly strong cultural, ethnic, and religious biases which place them at an even greater power imbalance in their relationships, HIV prevention messages must be tailored to reach these women in a safe, linguistically and culturally appropriate manner.

In addition, as shown in Chapter One, statistics commonly group lesbian and bisexual women together as a single category, which makes identification of exclusively lesbian issues difficult. This mix of data-gathering also makes it almost impossible to separate lesbian behavioral data. For many years, this has not been seen as a research priority, as it has been thought that female-to-female transmission is the lowest risk category.

Unmet Needs

When the needs of women are assessed against the range of services as described in Chapter Two, several conclusions emerge.

The highest risk group of women is those who fall into every risk category: African American or Hispanic IDUs who engage in sex with men.[8] These women share both the risk of transmission from multiple sources as well as the strongest cultural barriers to behavior change.

For these women, the greatest unmet need arises from the fact that, although there is a wide range of services which target a particular discrete need which these women face, there are no services which address the overall context in which these needs arise.

For instance, it has been demonstrated that programs which specifically target needle-exchange and bleach use by IDUs are generally successful in altering IDU behavior. Such programs fail to take into account the circumstances and

[8]Providers in the Asian/Pacific Islander community point out that research is necessary within the API sex industry community, as there is a strong perception among many API providers that this is a high-risk population for which there is insufficient data.

pressures which lead to unprotected sex, and therefore address only part of the overall problem.

Similarly, programs which promote safer sex and condom use will not be effective if they do not take into consideration the realities within which these women live. One African American woman focus group participant related the fact that although condom use, as measured by the number of free condoms given out to people in her community from clinics and other distribution cites, appeared to be highly successful, the reality of the program is that people in the community had learned that they could trade condoms for alcohol at local stores.

While many programs aimed at high-risk women are successful at altering or modifying specific behavior, these programs must be adapted to work in coordination with other, similar programs in the same area targeting a different aspect of high-risk behavior. This overall coordination will make the individual efficacy of each specific intervention more effective. This statement is not intended in any way to downplay the importance of individual, discrete target interventions. In fact, such interventions are essential to the development of any prevention plan. *Instead, it is the coordination of these disparate efforts which constitutes the greatest unmet need, particularly in a city like San Francisco, in which there is such a high number of programs, and very little emphasis placed upon consolidation or coordination among these various efforts.*

Prevention programs targeting non-IDU heterosexual women have embarked upon the course of education and changing of societal norms which all research has indicated is essential. Programs which take into account linguistic and cultural barriers, socioeconomic factors, the needs of refugee and immigrant populations, and better train providers in issues of access, systems of care, and sensitivity to women's needs will be more effective in transmitting prevention messages. These programs need to be continued, and refined to meet the cultural and linguistic needs of their target populations. As with all populations, messages are best delivered by peers.

For lesbian and bisexual women, the greatest need is to gather data and disseminate information in a manner which genuinely reflects lesbian behavior. Programs must address the fact that some lesbian women self-report repeatedly having sex with men. In addition, most IDU programs do not tailor their prevention messages to lesbians. Such programs need to take into account that many IDUs are either lesbian, or engage in sexual activity with lesbians, and modify their programs and materials accordingly.

Transgendered Male-to-Females (MTF)[9]

> *"You know, when people find out what you are, they discriminate, because the first thing that do come to their mind is AIDS. You know, and then they get nervous, and then they get scared that they might lose their clientele because of it. But it's not very much so...You know, and I don't have AIDS, or the virus, or anything else like that. I been blessed not to get it. But it's just the fact that it's hard to find a job and make it in society that way without bein' discriminated against, because of what you are. My goal isn't to get a sex change operation. I'm quite content with the way I am. I want to look more of a female. I like the illusion. But I don't want to cut off what I have. Because I don't want to pretend to be something I'm not. It's hard, though. Because I'm not ashamed. If you was to ask me what I am, I would tell you, even though it's really none of your business, I would tell you, just to let you know that I'm not ashamed."*
>
> *-- Transgender focus group participant.*

Accurate demographic information for the transgender population is not available, either in San Francisco or for the United States in general. Within the US, estimates on the size of the transgender population vary from 20,000 to 200, 000. It is thought that transsexuals account for 2% of the total United States population.

Per Kiki Whitlock of the Asian AIDS Project, research as conducted by local transgender advocates, educational media (i.e. television and transgender print media like FTM), and the Human Rights Commission, indicate that there are between 4,000 and 6,000 transgender people in the Greater Bay Area.

The term "transgender" is a difficult one to categorize, and has been used to include pre- and post-operative transsexuals, cross-dressers (transvestites), drag, and men and women who choose to pass as members of the opposite sex. An important element of transgender identity is that of self-identification. For instance, at the San Francisco STD clinic, transgender clients often choose to identify as "male" or "female" rather than as "transgender." While the importance of allowing transgendered people to identify their gender as they wish is obvious, it also makes accurate statistical data gathering difficult. Classification by sexual orientation is equally problematic. Transgendered people self-identify as gay, lesbian, and heterosexual.

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[9] This section includes only information on male-to-female transgendered people. No female-to-male transgender information or focus group participants were available for this report.

Statistics for further transgender classification do not currently exist. For instance, although it is widely perceived that the number of transgendered Male-to-Females (MTFs) in San Francisco is much greater than the number of transgendered Female-to-Males (FTMs), accurate statistics are not available. In addition, the number of pre-operative versus post-operative transgendered people is not known.

Prevalence and incidence data is equally lacking. No studies are even available which estimate broad HIV infection rates or predictions for this community.

Behavioral data for transgendered people is almost entirely based on limited focus group and other qualitative data, as not one statistical, quantitative study has been done for this community. Qualitative data shows the following behavioral trends in the transgender community:

1) A very high number of transgendered people work in the sex industry. For many transgendered people, this is often the only option open to them to earn a living. And even for those who are able to access more mainstream employment, simply being a transgendered person creates risks. Said one focus group participant, "I *have a degree in college, and I've been to school. But it seems like every time I find a job, there's somebody there who finds out what I am. And then they want services for what I am, so they won't tell my foreman, or my boss. And then if I don't service them, they tell the boss, and then the boss will give you some lame excuse, like, 'Well, I don't know which bathroom you should use.' Or something like, 'You gonna disrupt the flow here. So I think it's best that you leave. And we'll just give you some money to go.*"

Experiences like this drive many transgendered people to feel that prostitution is the only way for them to earn a living. Serving as sex workers inherently places transgendered people at high risk for HIV infection. This reality is exacerbated by the fact that transgendered people can often charge their clients more money for unsafe sex acts than for protected sex acts. (This is also true for other sex workers.) For instance, in the API transgender community, which is one of the larger of such communities in San Francisco, "Reinforcement of high risk practices exist through pressure from clients or 'dates' who pay a premium price for unprotected oral and penetrative anal and vaginal sex."[10]

2) Issues of self-esteem play a pivotal role for members of the transgender community. A common theme among transgender focus group participants is a sense of being ostracized or ignored by both gay and straight communities. Said one focus group participant, "*Since the virus has come out, the gay community as a*

[10]"Frameworks for Change," Report of the Multicultural Liaison Board, California State Office of AIDS, Working Draft, July, 1994, p. 34, section 4.8..2.1.

whole has united a great deal. But as far as what I've seen in San Francisco, in just this surrounding community, they don't give a fuck about us, , and they don't give a fuck if we live or die, or if we get hit by a bus. It doesn't matter if we die of AIDS. Just because of the simple fact of what we are, we don't matter. They would much rather us just not exist at all."

This sense of isolation and lack of support extends to prevention service organizations. Aside from a few specific organizations like the Tom Waddell Clinic, the Brothers Network, Asian AIDS project, and the Tenderloin AIDS Resource Center, which have specific transgender-targeted programs, transgendered people report feeling unwelcome or alienated by existing prevention service organizations. This alienation is amplified by the fact that available programs do not meet transgender needs, and that there is a lack of peers or role models in service delivery roles.

As a result of these psychological and social influences, transgendered people report increased high-risk sexual activity, a sense of inevitability about contracting HIV, and a feeling that taking proactive steps to remain healthy must be done entirely by the individual, because there is not a supportive, organized peer community that encourages safe behavior. This sentiment is usually accompanied by the realization that, even though San Francisco lacks a structured transgender support system, it is probably still the best city within which transgendered people can live and work.

For instance, within the API community, "many turn to denial as a coping mechanism. Transgender clients will accept and request condoms, but will avoid any discussion about HIV; moreover, many transgendered people have not accessed HIV testing. Some transgendered people will admit unsafe sex with their primary partners or boyfriends, many of whom are involved in high risk activity including IDU. Furthermore, health care services are inaccessible because of language barriers, cost, and unfamiliarity with the health care system....The rejection and abandonment of family and community support systems breed low self-esteem and attitudes of neglect -- attitudes that undervalue one's worth. They are marginalized even in gay/bisexual communities, and bar owners often see them only as commodities that attract customers and "dates" to their bars."[11]

This idea was brought home by one focus group participant, who said, *"In San Francisco, I agree, there's more support than anywhere else in this country. I don't have support from my family, and there isn't, even in San Francisco, total support. I don't feel we're treated as humans!"*

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[11] Id., pp. 34-35.

3) Among transgender focus group participants, there also appears to be an internal hierarchy between those who wish to, and are able to, "pass" as members of their chosen gender group, and those who either cannot or do not wish to do so. For instance, one focus group participant stated that, "I work with straight people. I'm out there working with them constantly...it's just a fact that they don't realize that I'm right in the midst of them. I've been in the midst of them all my life, and it would be a shock to them for me to say, 'Well, guess what!'" As a group, those focus group members who were able to "pass" also showed the greatest confidence in being able to remain HIV negative, as well as exhibiting control over their own sexual activity and the boundaries within which they are willing to take risks, if any.

The lack of reliable epidemiologic and demographic data, combined with the extremely high risk transgendered people face, create an open-ended list of needs for this community. Unlike other at-risk communities, there is no area where transgendered people feel that their needs are being met in San Francisco. Within the projects funded by the AIDS Office in 1992-1993, not one project or program specifically targeted transgender clients. [12] While this has changed slightly in 1994, in particular with the four programs mentioned above, the fact remains that everything from basic educational outreach to basic data gathering remains to be conducted for this community.

Unmet Needs

While this list is highly qualitative, focus group participants identify the following unmet needs as being of greatest priority (this list itself is not ranked in any particular order):

1) Peer support groups within which transgendered people can learn about HIV issues, as well as gain a sense of community and belonging.
2) A safe environment like a shelter, either in a community based organization or a community center, where transgendered people can go to get information or emergency help, or just use as a place to hang out and socialize with other transgendered people. Such an environment is seen as providing a sense of validation and self-esteem for all transgendered people.
3) Outreach programs which target transgender sex workers, and which provide both HIV information and counseling.
4) Vocational training services which provide an opportunity to leave the sex industry.

[12] Asian AIDS Project did receive money from the AIDS Office during this period which was directed towards transgender clients, but no money was specifically given towards an exclusively transgender-targeted program.

5) A greater presence of transgendered people in HIV Prevention and AIDS services, so that transgender clients can feel more comfortable with peers when accessing services. In addition, this policy would provide more transgendered people with alternative employment options from the sex industry.

All transgendered people report discrimination as a dominant issue in their lives, and many of the suggestions for addressing unmet needs either directly or indirectly address ways in which to tackle the pervasive issue of societal discrimination.

Transgender advocates recommend that future research differentiate between male-to-female and female-to-male transgender needs. In particular, female-to-male information must be gathered, as issues facing these populations are the least known.

Homeless Adults

Current estimates place the homeless population of San Francisco at between 11,000 and 16,000 people. Single men comprise about 45% of this population, and adults account for between 80-90%. Substance users form another 45% of this community.[13] The San Francisco Department of Public Health puts the substance use figure among homeless people slightly higher, at 50%.

Current ethnic composition figures are not available, but during 1986 and 1987, the Health Care for the Homeless Program reported the following race/ethnicity breakdowns for San Francisco: 54% Caucasian, 32% African American, 9% Hispanic, 2% Asian, and 1% Native American. When compared to current census data, these figures indicate that Caucasians, African Americans, and Native Americans are over-represented in Homeless populations, while Asian/Pacific Islanders and Hispanics are under-represented.[14]

To date, the most representative, cross-sectional study of HIV infection and behaviors among homeless adults in a major US city was conducted in San Francisco. This study sampled 1,226 homeless adults from shelters and lunch lines between 1990 and 1992. The seroprevalence of this population was 8.5%, with 90% being asymptomatic, and 75% unaware of their HIV status.[15]

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[13]"The Nature and Extent of Homelessness in San Francisco," 1994 Comprehensive Housing Affordability Strategy, U.S. Department of Housing and Urban Development, Final Draft, November 5, 1993, Part B2, p. 65.
[14]Id., p. 64.
[15]For more detailed data on this population, please refer to Chapter One.

Other figures for HIV seroprevalence within the homeless population vary greatly. A 1991 study by the University of California at San Francisco Medical Center found that 10% of the homeless people tested during this study were HIV positive. In 1993, the CARE Council reported that service providers estimate the seroprevalence within the homeless population to be between 20-33%. And a 1993 study conducted by UCSF, based on a survey of 2,000 homeless persons in San Francisco, estimated that 95 of these people were HIV positive.[16]

For homeless men, HIV infection is most likely to occur through homosexual or bisexual activity, selling sex, and injecting drugs. Younger men are at increased risk compared to older men. For women, injection drug use is the best behavioral predictor of HIV infection.

Homeless people are at great risk for HIV. Because of the high cross-over between homelessness and IDU and substance use activity, homeless people share many of the transmission risks of IDU populations. In addition, it is estimated that about 30% of homeless people are also mentally disabled.[17] HIV infection risks are exacerbated by all of these conditions.

Unmet Needs

Like transgender populations, homeless populations show a nearly universal list of needs when it comes to HIV prevention services. And like transgender populations, because so few needs are being met, the list of needs and that of unmet needs are essentially one and the same.

Many of these needs are not HIV-specific, but are closely related to HIV issues. For instance, the 1993 Polaris survey of homeless persons in emergency shelters concluded that most homeless people are unable to transition to a stable housing situation before having to leave shelters, and that few shelters provide follow-up or case management services after clients leave. In addition, the Polaris findings indicated that 50% of homeless families who are able to move from shelters to permanent housing are homeless again within 6 months, due to a lack of economic and social support needed to maintain housing options. For those who want to access shelters, lack of space is a common obstacle. The Independent Housing Services reports that in the month of June 1993 alone, 1,502 families were turned away from shelters.

The impact upon HIV prevention planning is two-fold. First of all, homeless population demographics show that the risk for HIV infection for these groups

[16]See Housing Affordability Strategy, supra, p. 76.
[17]Id., p. 65.

often comes simultaneously from multiple sources. For this reason, HIV prevention for homeless people must be integrated into all social services, like shelters, lunch lines, free clinics, and street outreach programs. Because homeless people often do not prioritize HIV prevention as a major issue in their lives (particularly when compared to the need to access food, shelter, and other basic necessities), programs designed to attract this population on the basis of HIV education or treatment alone will often be ignored. Instead, HIV messages must be integrated into a more holistic set of services which target homeless people's more immediate needs.

Outreach is particularly important in accessing homeless adults, due to the large numbers of people who are either turned away from shelters, or through physical or mental disabilities are unable or unwilling to access shelters.

Another unmet need which must be explored in greater depth is the linkage between HIV infection and homelessness. Homelessness and HIV infection often result in a "vicious circle" of circumstances which runs in both directions. In other words, homeless people, by nature of their environment, are exposed to a multiplicity of high-risk behaviors which can lead to HIV infection. At the same time, HIV infection is very often a major cause of people becoming homeless. "HIV infection among those with marginal resources can be a direct cause of homelessness."[18] If this occurs, these newly homeless people then not only become exposed to the high-risk behaviors which can lead to secondary infection, but also, through these same behaviors, increase the risk of transmitting HIV to others in the homeless community.

For a more comprehensive discussion of the type and scope of research needed to better assess the unmet needs of the homeless population, please refer to the Behavioral Summary and Epidemiologic Profile information contained in Chapter One.

[18] Id., p. 76.

Immigrants

Demographics

According to the most recently available census data, San Francisco's population is 28% foreign born, with 17% of the city's current immigrant population having arrived between 1987 and 1990. There is no detailed estimate of HIV seroprevalence among immigrants in San Francisco.

The San Francisco Unified School District's 1993 Youth Risk Behavior Survey showed that 16% of all students in the survey had lived in the United States for three years or less. Fifty percent of students in the school district speak English as a second language, and according to the Coleman Advocates study conducted in 1993, 28 percent of students in the district have limited or no English proficiency.

Ethnic and racial breakdown statistics for documented immigrants vary, but according to census data on language proficiency, nearly 63,000 people in San Francisco consider Spanish to be their primary language, of which 30% (18,900) have limited or no proficiency in English. Asian/Pacific Island languages are spoken by about 143,000 people, for whom 39% (55,700) have limited or no proficiency in English.

Neither of these studies include statistics for undocumented immigrants, and such statistics which are available vary greatly due to the lack of accurate tracking by either government or private organizations. As mentioned in Chapter One, ethnic and racial breakdowns for San Francisco's immigrant population indicate that people from China, Hong Kong, the Philippines, Central America, and Mexico currently comprise the largest populations of undocumented immigrants in the city.

Unmet Needs

Almost nothing has been done to assess the specific HIV-related needs for immigrant populations, either documented or undocumented. Because many immigrants, both documented and undocumented, are positioned at the lower end of the socio-economic spectrum, future research might be designed to test whether strategies which are targeted towards these populations might also be effective for immigrant groups.

In addition, programs aimed at specific minority groups, particularly Hispanic and Asian/Pacific Islander populations, should be examined for their potential applicability to immigrants. While many of these studies do include information from immigrant participants, none of them specifically address immigrant needs in isolation from other factors.

For immigrant populations, then, basic epidemiologic information gathering must be conducted prior to developing an assessment of priority needs (either met or unmet).

As information about immigrants does become available, prevention planners will have to choose from a list of strategies and interventions that include both legal and illegal activities. Because immigrant populations include illegal and undocumented aliens, planners must decide whether to include such populations in the groups they target and serve. Potentially running afoul of the law is not a new issue to prevention planners; such issues arose in the early days of needle exchange programs for IDUs. The importance of raising this issue lies in the fact that planners must carefully consider whether or not illegal and undocumented aliens should be included in services targeting immigrants, and design their procedures accordingly.

Incarcerated Adults

As indicated in Chapter One, as of July 31, 1994 there were 246 female and 2,208 male paroles in San Francisco (California Department of Corrections). According to the San Francisco Sheriff's Department (June, 1994), the average daily census of the four San Francisco county jails is 2,400, up 11.4% from the previous year. Ninety percent of the inmates are male, and 10% female. The population is mainly comprised of ethnic and racial minorities: 50.2% African American, 27.4% Hispanic, 19.4% European American, 1.6% Asian and 1.2% Native American and Samoan. Approximately 70% of those in custody have substance abuse problems, and many are injection drug users.

Although no published behavioral studies have been conducted with incarcerated adults in San Francisco (unpublished studies have been conducted), a recent cross sectional behavioral survey was done in the neighboring Contra Costa County Jail. This study sampled new arrestees who had been held in custody for three days or longer.

Most of those who participated in the Contra Costa study self-identified as heterosexual, and 73% were in a primary relationship. Over half of the sampled population had two or more partners in the past month, and condom use was

lower when having sex with a primary partner. Alcohol and drug use was high in this sample, with 22% drinking alcohol daily, 53% using marijuana, 30% using crack or cocaine, 31% using crank, and 11% using heroin in the past year. When comparing the behaviors of this sample to a population-based sample surveyed with the same instrument, the incarcerated population was found to initiate sex at an earlier age, have intercourse more often, and was more likely to be classified as "high risk".

Several unpublished studies of the San Francisco jail population which document a profile of inmate medical and social service needs have been conducted. A review of the current literature suggests that the jail population, because of individual behaviors and demographic characteristics, are at high risk for HIV, STDs and TB. In addition, in 1992, a voluntary HIV testing program began. To date, 1,200 inmates have been tested. The seropositivity rate is 8% for men and 16% for women.

In 1988, the California Department of Corrections conducted a cross-sectional, blinded study to estimate HIV seroprevalence among incoming prisoners in California. This study found an overall seroprevalence of 2.5% among the 5,372 men tested and 3.1% among the 807 women tested. Seroprevalence was more than twice as high among men arrested in the San Francisco Bay Area (5.3%) as in those arrested in Southern California (1.9%) or Central California (1.2%). This study did not collect information on risk behaviors; however, the authors speculate that the higher seroprevalence rate among men arrested in San Francisco is due to the increased seroprevalence among IDUs in San Francisco.

Unmet Needs

Provision of HIV prevention services to inmates in correctional institutions, as well as those in ancillary criminal justice systems, occurs on a regular basis in San Francisco. Incarceration provides the opportunity to reach some of the people that are the hardest to reach (IDUs, other substance users, and socio-economically disadvantaged). Many of these populations may not avail themselves of community programs.

Education and prevention efforts should continue to be tailored to inmate populations. Such programs must be culturally appropriate since non-white populations are over represented in the criminal justice system. Prevention efforts need to be done at several points throughout a person's incarceration period: upon entry into a correctional facility, repeatedly during incarceration, upon release, and also in the communities in which the prisoners will live when released.

Condoms and bleach must be readily available to populations while they are incarcerated. This latter provision is one of the greatest unmet needs which can have the greatest immediate effect on prevention efforts for incarcerated populations.

Finally, in order to maintain and encourage behavioral changes, incarcerated individuals need case management when leaving custody, to provide information and access to housing, drug treatment centers, and coordinated care with other community based organizations, hospitals, and municipal and state services. This need for coordination of HIV-specific and non-HIV-specific services is explored in greater depth in the preceding section on overarching themes.

Conclusion

Identification of Target Populations is helpful in determining how strategies and interventions can be adapted for greater efficacy when applied to specific groups or communities. Moreover, analysis of target populations is particularly important in order to understand those situations in which only specifically created programs and interventions will be effective within those populations.

When examining target populations, however, wider overarching themes must never be lost. It is these themes around which prevention efforts must be planned on a broad-based scale, for these are the areas which affect all groups, including target populations.

The next section will examine primary needs for future planning efforts in San Francisco, before moving on to Goals and Objectives, Linkages, Technical Assistance, and Evaluation concerns.

IV. CONCLUSION: HIV PREVENTION PLANNING MUST BE SEEN AS A CONTINUING, EVOLVING PROCESS

> *"You know what? I just want to hit on a point. I honestly think that, as many years as we all been shooting dope, and fucking around, I kind of get the sense that we can all still use a lot more education, you know?"*
> *-- Latino IDU Man.*

If all of the work and time of the planning council, the AIDS Office staff, the consultants, the focus group participants, and everyone else who has participated in the creation of this document had to be condensed into one core concept, that concept would probably be "Perspective."

Proper perspective is the cornerstone around which any legitimate, thoughtful planning process must be built. It is a concept which each and every member of the planning council has struggled with deeply during the course of this project.

Members' perspectives have revealed themselves in a variety of ways. For some, it surfaced in strong concerns that the brevity of the CDC timeline made comprehensive, thorough planning an impossibility. For others, the enormity of the gaps in available data put into doubt the ability that realistic, substantiated analyses could legitimately be made. And for others still, perspective took on the form of how, on an evolving continuum of time, this product should be viewed.

This last issue is a critical one, because it goes directly to how and why people were drawn to contribute to this planning effort.

The issues of HIV prevention planning can be viewed as somewhat analogous to the Greek mythological figure of Sisyphus, who is consigned to an eternity in Hell of pushing an enormous boulder up a steep cliff. If he can ever push the boulder to the top of the cliff, he will be freed. But every time he nears the top, the boulder slips from his grasp and rolls to the bottom again. He knows that he will never succeed in casting the boulder off the edge of the cliff, but he also knows that he must never stop trying.

The enormity of the task of developing a comprehensive HIV prevention plan is, for many, viewed in the same perspective as reaching the top of that cliff. With medical knowledge changing almost as frequently as community norms, HIV planning is a constantly evolving, malleable process. These shifting unknowns are made even more daunting because the few stable issues are often the most difficult to change.

Issues of self-esteem, mental health, poverty, homophobia, racism, and sexism are issues which have plagued communities long before the onslaught of AIDS, and will no doubt continue long after AIDS itself has perished. What makes AIDS prevention planning so difficult is that the causes of risky behavior are so often inextricably linked with these larger societal issues. Therefore, in order to effectively address behavior change to stop risky behavior, these larger issues must, in some small way, also be directly addressed.

Perspective, then, becomes the key word here again, for it describes the best way in which the context of AIDS prevention work can be viewed against the backdrop of these greater human issues.

Throughout this chapter, and those which precede and follow it, recommendations are made which will require great resources, time and effort to accomplish. What is important about these recommendations is to view them in the proper perspective. It is not expected that issues such as self-esteem or homophobia can be cured in one year or ten years. What is expected is that small, discreet, measurable steps towards curing these issues can be developed, implemented, and evaluated by HIV prevention planners in a realistic, timely fashion. Once again, such efforts will require both better data gathering resources as well as continuity of management.

The perspective relevant to this planning effort, then, is that of continuity. This project cannot, and must not, be viewed as a discrete, one-time effort which will end when the words on this page are printed and delivered to the CDC. To do so will invalidate the efforts and experiences of all those who participated in its creation. No issue as large as HIV prevention can, or should, be reduced to a single report or planning effort. Truly effective results can only be developed with time: time to gather data, time to develop programs, time to evaluate those programs, and time to revise and adapt programs to take into account successes, failures, and changing external conditions.

The final recommendation of this chapter, and perhaps its most crucial one, is therefore that the HIV planning bodies which this plan helped to create be seen as part of the permanent HIV prevention community. This planning process, and this planning document, must be seen as the first small step in a very long journey. All parties involved, from the CDC to the AIDS Office to the council members themselves, must view their role from the perspective of having started something, not finishing it. This process has raised more questions than it has answered, and a commitment must be made to working towards those answers, however long that road may be.

The suggestions and ideas posited in this report must be seen exactly, and only, as that: suggestions and ideas. They are not solutions. They are not definitive answers. They were never intended to be so. The current state of HIV prevention planning in any city, anywhere in the world, is not at the stage where such answers are available. If they were, there would be no more HIV infection.

What is presented here, then, is the best guesses which the best minds in San Francisco believe to be the initial steps towards creating a truly viable HIV prevention planning process. It is not the answer, but it is the honest result of endless hours of hard work, animated debate, and thoughtful deliberation by people who care deeply about, and have been personally affected by, this terrible epidemic.

Chapter 6:

Goals and Objectives

CHAPTER 6: GOALS AND OBJECTIVES

PREFACE

The HIV Prevention Planning Council (HPPC), in adopting these goals and objectives, and the AIDS Office, in incorporating them into its operational strategies, have accepted the fact that HIV prevention can only be successful if it focuses on the behaviors that place people at risk for HIV transmission.

Moreover, the HPPC recognizes that prevention will only be successful for the community as a whole if the various prevention efforts work in concert with each other. Thus the plan emphasizes standardizing essential aspects of prevention so that planning and evaluation can meaningfully take place at the system level.

Finally, the plan recognizes the need for tailoring specific prevention strategies and interventions to the needs of distinct populations of people at high risk for contracting HIV.

About the Plan's Goals and Objectives

The CDC Guidance calls for "goals and measurable objectives that are programmatically meaningful for HIV prevention in defined populations." This requirement is virtually impossible at this time. Two factors account for this difficulty. First, because prevention efforts are not organized with similar methods or measures, it is very difficult to assess the experience and results from different programs. Second, there have been very few evaluations of interventions measuring success in terms of outcomes, either through reduced seroconversions or sustained changes in risk behavior.

Thus, this plan does not pretend to put forward "measurable objectives" for which no infrastructure exists by which to measure and evaluate. Instead, this plan is built on a two-fold approach to this problem. First, this plan identifies specific steps to be taken in the next year which will improve standardization, and improve the overall system of data collection, reporting and analysis. This will enable different providers to compare their data, and adjust the specific levels of behavior change expected from different populations. Second, this plan requires flexibility in the system so that as more literature and information become available, prevention efforts in San Francisco will be able to incorporate these results into new goals and objectives. Significant progress on both these steps is foreseen in the next year.

The Role of the AIDS Office and the Community

The AIDS Office is charged with the responsibility for overseeing the city-wide implementation of the Goals and Objectives contained in the HIV Prevention Plan for San Francisco as adopted by the HIV Prevention Planning Council. In 1995 the AIDS Office will develop a Request for Proposals (RFP) which specifically calls for proposals for projects which will implement the Goals and Objectives which follow. Implicit in the identification of a new paradigm for HIV prevention in San Francisco, with its emphasis squarely on behavior change, is the recognition that prevention is a community process which requires aggressive outreach to all communities and linkages with governmental, community-based, religious, business, and educational bodies.

GOALS AND OBJECTIVES

Goal 1: **Reduce new HIV infections in the City and County of San Francisco to as close to zero as possible by the year 2000. To do this, we will target both HIV(+) and HIV(-) communities.**

Objective 1: All providers will measure clients' risk behaviors and involvement in other interventions in a standardized manner.

A) When possible providers will follow-up with intervention participants and measure the same behaviors 6 months later, in order to document a minimum of 15% reduction in risk behaviors.

B) In those instances where tracking and follow-up is not possible, providers will measure the behavior change of a similar population.

Objective 2: Prevention strategies and interventions selected for implementation shall be consistent with goals and objectives and with the priority setting criteria established by this plan.

Objective 3: The AIDS Office will ensure that primary HIV prevention activities are linked with secondary HIV prevention activities:

- through similar, consistent messages throughout the continuum of HIV services
- through regular joint meetings for primary and secondary providers
- and, as appropriate provide primary messages at places where people are seeking secondary treatment.

Goals 2: **The AIDS Office will standardize units of service definitions for HIV prevention services by the end of 1995, so that the work of different providers can be looked at in the context of the overall prevention effort in the city.**

Objective 1: An ad-hoc committee of providers, DPH staff and researchers will be convened by the AIDS Office to assist in the development of the standardized units of service.

Objective 2: Once standardized units of service have been adopted, new and existing providers will be given 3 months and 6 months respectively, to incorporate these standards into their contracts and information collection systems.

Goal 3: **Make evaluation possible: establish a standard evaluation system for prevention efforts.**

Objective 1: The AIDS Office will develop a plan to standardize collection of service data by all prevention providers.

Objective 2: The AIDS Office will organize this data, and make it available to all prevention efforts in San Francisco, by the end of 1995.

Goal 4: **All HIV prevention providers in San Francisco will have the technical and administrative capabilities to provide competent and appropriate prevention programs.**

Objective 1: The AIDS Office will assess the technical and administrative capabilities of all HIV prevention providers in San Francisco.

Objective 2: The AIDS Office will coordinate the delivery of sufficient technical assistance to providers in a number of areas including: incorporating the new standardized units of service into proposals, evaluation and reporting efforts, staff training, computer system development.

Goal 5: **Prevention efforts shall be culturally appropriate.**

Objective 1: The HPPC and the AIDS Office shall develop a definition of cultural competence and cross-cultural competence that addresses staffing, training, governance, service provision, evaluation process, and client satisfaction, and that recognizes the diversity of the population of San Francisco, not limited to language, ethnicity, race, national origin, sexual orientation, etc.

Objective 2: Prevention providers and the AIDS Office shall demonstrate that programs and agencies are culturally competent consistent with the definition developed in Objective 1.

Chapter 7:

System Linkages and Coordination

CHAPTER 7: SYSTEM LINKAGES AND COORDINATION

PREFACE

The purpose of this chapter is to identify the coordination and linkages between the AIDS Office, local government, HIV prevention providers, the private sector and the broader community necessary to facilitate the accomplishment of the Goals and Objectives outlined in this HIV Prevention Plan. Toward this end, the goal of cultural competence and the specific objective regarding the coordination of primary and secondary prevention efforts will guide all activities noted in this section.

Linkages relate primarily to information-sharing and referrals, while coordination implies action, decision-making, or the common effort(s) of multiple groups and organizations to accomplish shared or related goals. In this instance, coordination blends, integrates and maximizes resources and leads to a system which facilitates complementary programs and which is greater than the sum of its parts.

AIDS OFFICE

Goal 1: The AIDS Office will ensure that services will be delivered in a way that is consistent with the priorities established in this plan.
Objective 1: Units of service will be standardized.
Objective 2: Services will be funded and supported in a way that makes best use of resources--should not duplicate services in a way that exceeds one need as long as other needs are not being met.
Objective 3: AIDS Office will provide coordination of all contracts.

Goal 2: The AIDS Office will develop and enforce the utilization of standardized assessment tools and measurement of outcomes.

Goal 3: The AIDS Office will ensure that similar messages, and a minimum level of information, about prevention are disseminated throughout the system of prevention providers.

Goal 4: The AIDS Office will set minimum standards for AIDS prevention services, including outreach, one-on-one level intervention, group level intervention and community level intervention.

Goal 5: The AIDS Office will set minimum standards for staff knowledge and skill requirements based on a combination of education and/or relevant experience.

Goal 6: The AIDS Office will provide assistance to CBOs in gaining access to other city government venues for prevention efforts, e.g. MUNI advertisement space.

Goal 7: The AIDS Office will coordinate efforts to offer cost-effective joint purchasing of goods and services, and benefits, etc. to contracted primary and secondary providers..

Goal 8: The AIDS Office will provide a forum, and require attendance for contracted providers, for prevention providers to gather and discuss ways to maximize the impact of prevention services.

Goal 9: The AIDS Office will actively promote linkages with other networks of service providers through a variety of mechanisms including newsletters, forums, joint projects, conference training, meetings between the CARE Council and the Prevention Council. The groups to be contacted include the following:

- research institutions
- other professionals who may be indirectly involved in HIV prevention, such as social workers and psychologists
- non-city funded prevention efforts
- providers and government agencies in neighboring counties
- non-governmental organizations
- mental health providers and substance abuse treatment and prevention providers
- private sector
- all primary and secondary prevention efforts

HIV PREVENTION PLANNING COUNCIL (HPPC)

Goal 10: The HPPC will promote effective linkages and coordination throughout the entire HIV prevention network in San Francisco.

Goal 11: The HPPC will promote the integration of HIV/STD prevention efforts with drug and alcohol treatment and prevention, as well as mental health treatment.

HIV PREVENTION PROVIDERS

Goal 12: Representatives of San Francisco's HIV prevention providers will proactively establish linkages and coordinate their prevention activities with other public and private entities in order to enhance the overall HIV prevention effort.

Objective 1: HIV prevention providers will participate in AIDS Office sponsored meetings of prevention providers and will actively seek out ways and means of coordinating their HIV prevention efforts with other bodies serving the same or similar client populations.

Objective 2: Media campaigns and educational materials will be submitted to and reviewed by the AIDS Office both for appropriateness and technical accuracy of content and for consistency with behavior change messages recommended by the HIV prevention provider community.

OTHER BODIES

Goal 13: Linkages should exist between the San Francisco HIV Prevention Planning Council/AIDS Office and similar bodies responsible for HIV prevention planning in adjacent counties, the State of California and the nation.

Chapter 8:

Technical Assistance

CHAPTER 8: TECHNICAL ASSISTANCE

PREFACE

The burden of proof that HIV prevention works is now on service providers and prevention proponents. Funders and policy makers alike are asking questions: Will prevention programs reduce HIV risk among specific populations? Why are proposed programs likely to prompt behavior change? How can one be sure that programs are delivered in a manner likely to change HIV risk? What effects do specific prevention programs have on factors linked to HIV transmission? How long does behavior change last? Many HIV service providers need new skills to begin to respond to these questions.

The San Francisco HIV Prevention Planning Council, in heeding the CDC Guidance, has defined technical assistance as the provision of training or expertise that allows agencies to plan, implement, and evaluate prevention efforts more effectively. If one evaluates the skills needed by the pool of potential service providers and systematically offers assistance as needed, one can increase the capacity of service providers to meet progressively stringent standards of prevention. In the best of all possible worlds, the pool of contractors would mature so that, as the sociodemographics of the epidemic in San Francisco change, the SFDPH AIDS Office can respond rapidly and effectively to the needs of emerging populations. Technical assistance is an integral part of building an adaptive and effective HIV prevention program.

CHAPTER SUMMARY

This chapter presents implications from an exploratory study of the technical assistance needs of San Francisco prevention providers in the areas of planning, implementation and evaluation. A sample of 30 prevention agencies was selected by the San Francisco AIDS Office for participation in a series of focus groups and written surveys.

The broad implication from this initial study is that the sixteen respondent organizations agreed the three areas identified by the CDC are priority areas where technical assistance is required. The particular requests identified by respondents varied somewhat in emphasis, though they each asked for many things in common. For example, respondents agreed on many current barriers to effective planning and evaluation. They also agreed that some aspects of evaluation are likely to be best addressed at the system level through sharing resources, while others require each organization to develop the requisite internal expertise and infrastructure. Particular suggestions raised through both focus groups and survey responses in each area are detailed in this chapter.

A follow-up survey and series of interviews were also conducted to add depth to our understanding of the technical assistance needs. The additional agency surveys confirmed the earlier findings noted in the discussion which follows in the body of the chapter. Interviews with the grantee, the San Francisco AIDS Office, and with other providers of technical assistance identified additional needs of the grantee, and highlighted differences in perspective.

AIDS Office respondents identified 2 groups of technical assistance needed by the grantee. First, support in providing technical assistance *to prevention providers.* For example, developing standardized units of service, supporting compliance with reporting requirements, developing program strategies which utilize public health theory and translate into measurable, and fundable program objectives. The AIDS Office would like to work with third parties in delivering much of this type of technical assistance.

Second, respondents identified a need for organization development assistance for the AIDS Office itself. Time management, training for AO staff on the use of computers, and other professional development training were mentioned in addition to getting "help with its organizational structure to enable it to take advantage of skills it has in-house."

Finally, it is important to note that providers and the AIDS Office view the need for technical assistance from somewhat different perspectives.

Providers see a need for fundraising training, but did not identify financial management as a high priority for assistance. The AIDS Office, however, identified financial management training as an important need of providers. In the area of program planning, implementation and evaluation, providers were more interested in gaining access to information, computer resources and assessment of long term impacts than they were in writing better proposals and defining measurable objectives for current program activities. The AIDS Office is very concerned about providers abilities to develop more sophisticated program designs and improve service delivery and general operations.

The difference in emphasis seems natural based on institutional priorities. It is important to take this difference into account, though, in developing a technical assistance plan. If providers are going to attend sessions on topics identified as priorities by the AIDS Office--such as financial reporting--they must have an institutional incentive to gain proficiency in these areas (or fear a negative consequence for failure). For the AIDS Office to support the types of assistance prioritized by the providers--such as burn-out prevention and long term effectiveness--links must be drawn to direct improvement in the delivery of prevention efforts. The interests are not oppositional; they need to be balanced in delivering appropriate technical assistance.

TECHNICAL ASSISTANCE NEEDS ASSESSMENT: AN EXPLORATORY STUDY

According to the CDC Guidance, the HIV Prevention Plan must identify the needs for technical assistance in the areas of program planning, implementation and evaluation. This document reports the results of written surveys and focus groups examining the technical assistance needs of a number of HIV prevention service providers who received funding in 1994 from the SFDPH AIDS Office.

The document begins by describing the methodology of the HPPC's technical assistance needs assessment. It then offers separate findings about the need for technical assistance for program planning, implementation and evaluation. Finally, it describes findings regarding the perceptions of HIV prevention providers about technical assistance: what it is and what it isn't.

Methodology

The technical assistance needs assessment utilized written surveys and focus groups to collect the views and perceptions of a small sampling of the prevention providers funded by the San Francisco AIDS Office during 1994. Written surveys were sent to 30 agencies. A copy of the survey is attached as Exhibit A. Each agency was asked to complete the survey and return it by fax or mail to the HPPC's consultants. To encourage a higher rate of return, non-responding agencies were contacted and interviewed by telephone. The surveys were filled out by a random sampling of service providers and administrators. A total of 16 agencies competed and returned surveys.[1]

In addition to the surveys, four focus groups were conducted, each with four to six participants. Two focus groups consisted of service providers and two groups were composed of administrators. A copy of the focus group questions is attached as Exhibit B.

Description of Participating Agencies

The prevention providers that responded to the survey or participated in focus groups report targeting the following populations: HIV-negative gay and bisexual men; gay and bisexual youth and adults with substance abuse problems; active intravenous drug users in community settings; HIV-positive

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[1] The number of responses to individual survey questions does not always equal 16. Some agencies did not fully complete the survey. Also, some questions allow an agency to give more than one response, and some questions overlap with other categories within the survey.

transgendered persons; Latino gay and bisexual men; gay, bisexual and heterosexual men; African Americans in the southeast section of San Francisco; high-risk women; youth and their mentors, such as teachers and counselors; and gay and bisexual men.

Of the agencies surveyed, the largest number target youth and gay/bisexual men. A smaller number target African-Americans and women demonstrating high risk behavior, and the smallest number target intravenous drug users, transgendered persons and Latino gay and bisexual men.

Each of the agencies provides a combination of prevention services to its target communities, including: outreach; one-on-one education or counseling; group education or counseling; community organizing; media/events; training and technical assistance; community education targeting youth; HIV testing and risk assessment; lesbian/gay awareness in the schools to focus HIV education on HIV and not sexuality; and education on condom distribution. Most of the agencies represented by survey respondents and focus group participants provide group education or counseling. Many also offer outreach and one-on-one education or counseling.

PRESENTATION OF DATA

Although California still faces an HIV crisis, its intervention services are making inroads in primary prevention of AIDS.

> California's investment in HIV education and prevention is paying off. Community involvement in HIV prevention activities in California counties has grown, especially during the past five years. More departments of health and substance abuse, community-based organizations, voluntary and civic organizations, schools, churches and employers are involved in prevention activities.[2]

Survey and focus group participants share this general enthusiasm about the progress in HIV prevention efforts. Their comments nonetheless demonstrate a need for effective evaluation methodology, competent and well-trained staff, comfortable collaboration with other community-based

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2 HIV Prevention in California: Final Report HIV Education and Prevention Evaluation. Prepared for the Office of AIDS, California Department of Health Services by the Institute for Health Policy Studies, University of California, San Francisco. April 1993. p. 80.

agencies, training in everything from grantwriting to computer skills, program planning techniques and just time to think, re-orient, talk, train, and work with clients. Of course, money also is a consistent need. The following is a summary of the results of the survey and focus groups.

Planning

Survey respondents and focus group participants were asked several questions about program planning. This section addresses the planning processes participants used and the planning needs they identified.

Survey Results

Survey respondents were asked how their program got started and what planning process they used. Nine of the agencies represented by survey respondents started their HIV prevention programs without specific funding availability in response to perceived or stated client need. Seven initiated their strategies in response to client need with specific funding availability. One commenced its program in response to funding availability.

Eleven respondents reported their agency engaged in a formal planning process to develop their HIV prevention programs. Four respondents reported their agency did not engage in such a formal process, and one respondent was not sure what planning procedure had been used.

The respondents indicated using the following tools in order of priority to plan prevention programs: (1) analysis of methods of reaching clientele; (2) epidemiology of HIV among clientele; (3) training programs for staff; (4) HIV prevention materials for use in service; (5) epidemiology of behavior among clientele; and (6) epidemiology of surrogate markers of unsafe sex, such as STDs.

Survey participants then were asked to list and rank in order of importance from 1 [most important] to 5 [least important] the things (other than money) that would have helped them plan their programs.

For the purposes of this document, the responses are listed by targeted client population to show, without violating the confidentiality of survey participants, who is requesting what assistance. The particular needs of each individual agency serving that population may vary.

	Client Groups Targeted by Agencies (see key)								
Resources (other than money) that would help agencies plan their programs	A	B	C	D	E	F	G	H	I
Data regarding target populations	X	X	X	X	X		X		X
Data regarding prevention strategies and interventions		X	X		X				
Management and staff training			X	X			X	X	
Fundraising assistance			X						X
Coordination with or information regarding other service providers			X		X	X			

Key to Client Groups Targeted by Agencies

A - African-American community
B - HIV negative gay and bisexual men
C - Gay and bisexual male community
D - Gay/bisexual youth/adults with substance abuse problems
E - Youth and their mentors, such as teachers, counselors, etc.
F - Active intravenous drug users in community settings
G - Gay, bisexual and heterosexual men
H - High risk women's population in San Francisco
I - Transgender community

In addition to these general needs, some respondents noted more specific needs such as to coordinate more effectively with school administrators or to obtain additional support and information from the SFDPH. Several respondents also noted the need for additional time for planning.

Focus Groups

Focus group participants offered several ideas about program planning. First, they noted that field notes compiled by outreach workers can assist in planning. Outreach workers keep field notes on everything they do and observe, and then come back to administrators with information about the needs of certain communities. Based on this information, administrators seek funding for delivery of these services.

One focus group participant described the process of planning and funding a particular program, showing the planning value of data gathered by outreach workers.

We did outreach to the general community. We identified a group of immigrant women who work in massage parlors. They were non-English speaking and were very high risk. We realized that they were not familiar with the health services or social services in the country. These women worked within a very closed culture which included police harassment, gang activity, drug use, addictive behavior, gambling, etc. We had a woman on staff who did outreach for the massage parlor. This wasn't funded outside of the agency but absorbed into the agency budget. The outreach worker did mostly condom distribution in cooperative massage parlors. Soon we realized that the majority of these women were Vietnamese. So we hired a Vietnamese-speaking staff person and that opened the door. The women hired was a Vietnamese immigrant and began doing one-on-one counseling with the women in the massage parlors. Soon she was able to bring clients to the clinics to access Medi-Cal, Social Security, legal services, or whatever. This activity was not funded for about a year. Then, after identifying the need, testing the effectiveness of the services, we were able to obtain funding.

Focus group participants also identified the value of history in the planning process.

What were the goals five, ten years ago in similar programs? How much have the scopes of work changed? Have we restructured the ladder? Are we reinventing the wheel every time we fund a program?

When we award contracts we need to look back and see what has happened. We need to trace the evolution of this great idea. Tracing history can talk about obstacles that a program might face when starting up. Therefore, enough lead time can be given, recognizing that it may take 12, 16 or 18 months before the program becomes operational. This knowledge would be known because it would be noted as the experience of former contractors. And so that wealth of information would be available.

One participant also noted the need to develop a philosophical basis for prevention programs as part of the planning process:

I think we are responding to a particular situation without any careful analysis. We are missing an overall philosophy around prevention education in this city. A philosophy that would be

general enough to include all communities, but that communities could then take and specifically mold to their needs.

What is the theory behind prevention? We need to look at sources from public health, medicine, behavior sciences, etc. What is the theory behind prevention education, considering all these different factors and situations?

An additional planning concern discussed in focus groups was the development of standardized definitions of populations. Participants perceived a need to identify and define each segment of the population to give greater clarity in communications and possibly provide more effective interventions, but left open the question who identifies and defines.

Program Implementation

Survey respondents and focus group participants next discussed the implementation of their programs, characterizing their level of success and identifying obstacles and the types of assistance needed to overcome those obstacles.

Survey Results

Survey participants were asked to indicate how well their agencies implemented their HIV prevention program on a scale from 1 [least well implemented] to 5 [most well implemented]. Nine participants gave their agency an implementation rating of four. Three rated their agencies at five, while four participants only evaluated their implementation at a level of three. None of the participants evaluated their organization's services as below average in implementation, demonstrating a general belief in the competence of their programs.

Although participants generally believed their programs were well-implemented, they identified a number of obstacles they faced in carrying out HIV prevention programs. Three of the main obstacles faced by these service providers are hiring qualified staff, maintenance of a uniform service delivery system, and an inability to reach those in greatest need.

The obstacles identified by survey participants are the following (in order of priority):

1. Inability to reach those in greatest need;
2. Difficulty in retaining trained staff (recruiting);
3. Difficulty in obtaining information on methods of behavior change;
4. Difficulty in maintaining uniformity in the quality of service;
5. Increasing the level of community knowledge/information about HIV/AIDS;
6. Overcoming a shortage of staff and money for operational expenses;
7. Becoming better able to refer clients to programs that help them deal with fundamental barriers to safe behavior, such as good, accessible alcohol and drug treatment programs, empowerment skills, support groups for women trapped in abusive relationships, etc.;
8. Retaining participants or long term intervention;
9. Inability to serve a portion of those in need due to funding limitations, community and agency politics; and
10. The need for in-depth planning and implementation skills training for some staff.

Survey participants then were asked to numerically rate a list of types of outside assistance from 1 [least helpful] to 5 [most helpful]. Their responses demonstrate the following technical assistance needs (in order of priority):

1. Information on what works and what doesn't in HIV prevention strategies;
2. Cultural diversity training;
3. Community coalition network building;
4. Grantwriting;
5. Skill-building in group process;
6. One-on-one counseling techniques;
7. Program promotion;
8. Techniques for outreach;
9. Behavior change techniques;
10. Quality assurance; and
11. Access to research information on HIV prevention strategies.

Focus Groups

Collaboration with other agencies was a consistent theme expressed during the focus groups. Participants stated a strong interest in training and learning with people from other agencies. Participants recognized that such collaborations would fortify existing bonds, allowing professionals to learn about each other and about what they need from each other. In spite of an acknowledged competitive strain undermining collaborative efforts, the desire for true collaboration was very strong and was expressed frequently throughout the focus groups.

Focus group participants identified several specific needs for program implementation technical assistance. First, they said they need information about the legal system or consultation with attorneys. Often health workers find themselves in the position of being advocates for clients with health clinics, with the police, with the city social service agencies. Good knowledge of the law is instrumental in getting this part of the job done.

Second, focus group participants said it is important to come to the job with an open mind. When a health worker is involved with various populations, it helps to be able to talk to people. Without communication, the ability to perform intervention is severely curtailed. An ability to accept different lifestyles and relate to the humanity in everyone is essential to getting the job done.

In addition to technical assistance ideas, focus group participants discussed how they define success in program implementation. The following are some quotes from focus group participants about what success means to them.

> *When a client says, "Thank you for being here and caring about us."*
>
> *Empowering clients to do HIV prevention education [and] letting them know that this is what they can do. As a result of taking care of themselves through HIV prevention, becoming informed about the services and what we do, they can actually go out be HIV educators in their own communities.*
>
> *I go and do groups in recovery homes. Some of the recipients of the support groups have come in and volunteered at the agency. In this way they have empowered themselves and obtained some self-esteem.*

The clients have found out many things about treatment, including that it isn't as scary as they thought it was. So they've decided to begin to take care of themselves.

Successes must be gauged in small things. If I get someone to switch off shooting to snorting, that's a big success. If I get someone to switch from crystal to ecstasy, that's a big success.

We meet people and try to help them. Sometimes they start being safe and that's a success. It's very slow. One-by-one successes.

The way focus group participants define the success of their efforts is consistent with the World Health Organization's definition of disease prevention as the

> "process of enabling people to increase control over and to improve their health" (World Health Organization, 1986). WHO recognizes that prevention efforts work "through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavors and destines" (World Health Organization, 1986).[3]

Finally, focus group participants recognized that the ultimate success of HIV prevention programs may depend on whether other needs of clients are addressed. As one focus group participant indicated, the needs of clients beyond those directly related to HIV prevention also raise important issues for program implementation.

We should consider the quality of life of our clients. It is good to give them condoms but they have other needs, such as jobs, housing, drug addiction. What about these needs? We can't do HIV prevention in isolation of the other problems in peoples' lives.

How people construct their reality within the context of the epidemic. What are their concerns and issues that are important

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3 HIV Prevention in California: Final Report HIV Education and Prevention Evaluation. Prepared for the Office of AIDS, California Department of Health Services by the Institute for Health Policy Studies, University of California, San Francisco. April 1993. p. vii.

to the epidemic. How do people look at AIDS in terms of their every day life situations? - within the context of their loneliness? - within the perception of their attractiveness?

These questions are pertinent to providing effective service in HIV prevention and treatment. What is the big picture? How do these programs impact a client's total life, not just a piece? Of course, these are large questions with broad implications beyond the need for program implementation technical assistance.

Evaluation

Survey respondents and focus group participants were asked to identify which evaluation tools they currently use, how current evaluation data is used, what evaluation information they would like to obtain and which obstacles impede effective evaluations. The results indicate that participants recognize the great importance of effective, long-term evaluation strategies for appropriate program planning and implementation.

Survey Results

In response to a multiple-choice question, survey participants said they currently use the following evaluation tools: enumeration of the units of service provided; measurement of how well they met their process and/or outcome objectives; measurement of client satisfaction with services; measurement of client retention in their programs; evaluation of the changes in clients' HIV risk behaviors; tests of client knowledge before and after participation in their programs; examination of STD rates by census tract; bi-annual KABB surveys of clients to monitor changes that would indicate a need to change their approach, strategy or protocols; comprehensive one-hour interviews at admission and at follow-up interviews after six months; CDC-mandated outcome evaluation; and qualitative analysis and evaluation.

Some of these tools emerged as being more favored than others. All of the organizations represented by survey respondents used enumeration of the units of service provided. A significant number of agencies measured client satisfaction with services by utilization of various instruments. Most of the agencies also assessed their success by whether they met process or outcome objectives, and a large number evaluated the changes in their clients' HIV risk behaviors.

All participants admitted that they determine which aspects of their program to evaluate by collecting information mandated by their funders and making individual evaluation decisions based on the programs.

Once it is collected, the participant agencies use evaluation information in a variety of ways: to complete funders' reporting requirements; to prepare funding applications; to monitor and fine tune the content and implementation of their services; to develop new services to make overall program budgeting decisions; to make staffing decisions; to publish in reference journals; and to boost volunteer and staff morale.

All participants reported their agency use evaluation information for the dual purpose of completing a funder's reporting requirements and monitoring the content and implementation of their services. Most of the organizations represented also use the material to prepare funding applications, develop new services and make staffing decisions.

Survey participants then were asked what additional information they desired about the impact of their services. There was an unanimous desire for data that analyzes long term behavioral change. Survey respondents wanted to know what effect their interventions had on their clients' lifestyles. Were they reaching the communities they needed to reach? Did risky behavior decrease after prevention interventions? Was there a sustained increased awareness of safe sex techniques and HIV prevention practices? Did clients incorporate these changes into their lives on an ongoing basis? What is the relationship to seroconversion among clients and how does this correlate with interventions offered?

To better understand various communities, several of the organizations desired an in-depth ethnographic impact study to ascertain effectiveness. Consistent with this request was one for a knowledge, attitudes, beliefs and behaviors (KABB) study to be conducted in the African-American community.

The agencies that service youth wanted studies on their programs' impact on student attitudes, knowledge and actions. They wanted to know if there was a change in behavior and HIV status among students who were recipients of prevention workshops. Are the specific techniques used to reach the young people working?

Embracing the concept of peer outreach, some agencies wanted to know if clients took the knowledge given to them and shared it with others. These organizations wondered if they had been successful in instilling a sense of social responsibility. Do the clients advocate for others around HIV prevention practices?

Although survey participants indicated many ways evaluation information can be helpful to their agency, the Multicultural AIDS Resource Center of

California (MARCC) at Polaris Research and Development noted an attitude of resentment among organizations regarding evaluation.

> Evaluation is often conducted in a "hierarchical" atmosphere wherein the funding source often dictates that contractors implement evaluations without incorporating the contractor's needs and inputs in the process. Program evaluation is required but funding is not provided to carry it out.
>
> Only quantitative evaluation methods are recognized. Qualitative evaluation is neither encouraged, funded nor valued. As a result focus groups participants often referred to the State Office of AIDS as "bean counters" who are only interested in playing the "numbers game."[4]

Obstacles to Evaluation

Survey respondents identified the following obstacles to obtaining necessary evaluation information: lack of time; lack of expertise in evaluation; concern that evaluation would change the nature of the agency's services for the worse; lack of capacity to analyze the information gathered; lack of knowledge regarding where to get the information; lack of staff; difficulty, cost and invasiveness of following clients for long-term study; concern that many clients don't want to be bothered unless there is a monetary incentive, which then becomes an intervening variable; difficulty in obtaining parental permission regarding follow-up of youth; lack of funds necessary for tracking students after they leave class; and a simple lack of money.

Of these obstacles to obtaining necessary evaluative information, the greatest is a lack of time. A lack of capacity or ability to analyze the data emerged as the next greatest obstacle, followed by a lack of expertise in the development of evaluation tools.

The final question in the evaluation segment of the survey addressed issues about surmounting obstacles. The organizations were asked to state what would help them to overcome the obstacles they listed in the previous question. The responses were: change in funder reporting requirements; training on measuring behavior outcomes; data analysis capability; understanding of how epidemiological information relates to the program;

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4 Needs Assessment of California State Office of AIDS Education and Prevention Contractors and Subcontractors, Part II, "On Providing Technical Assistance to HIV/AIDS Prevention Service Providers." Results from 6 Focus Groups. Multicultural AIDS Resource of California (MARCC) at Polaris Research and Development, San Francisco, California. p. 3.

KABB studies funded by CDC and AIDS Office; more sensitive evaluation mechanisms; and additional staff for longer-term evaluation and assistance in data analysis.

Again, the respondent agencies highlighted their need for technical assistance in evaluation. It is clear that technical assistance around basic evaluative techniques is required to help prevention providers ascertain proper implementation of their programs.

Focus Groups

Focus group participants stated that they perform evaluations in order to trust in the effectiveness of their work.

> *Everyone needs to know they are doing their job and that it is being effective. Otherwise they become apathetic.*

According to focus group participants, many organizations evaluate the effectiveness of their program by the response of their clients. Some measurements of success include: (1) observations as recorded in field notes; (2) measurements of the extent to which people attend meetings, enjoy meetings and feel at home with others in the group; and (3) attitudes as reflected in client satisfaction surveys.

Focus group participants also reported evaluating their programs based on the traditional evaluative standard: meeting objectives.

> *We evaluate according to our objectives. If we meet our the objectives in the focus groups and focus interviews then we evaluate the service on this criteria.*

Attitudes About Technical Assistance

Survey respondents and focus group participants also were asked general questions to gauge their attitudes about technical assistance, including their definition of technical assistance, their past experiences with technical assistance, and their preferences for how technical assistance services should be delivered.

Survey Results

The definitions of technical assistance given by the participants ran the gamut from "a friendly audit of administrative systems" to "an empowerment process." "Helping agencies to do their work more effectively with the resources they have" was a general but inclusive definition. Some

participants viewed technical assistance as a process that contributed to a solution concerning ongoing problems, while others viewed it as specific help for an individual, time-limited issue.

Twelve survey participant agencies had used technical assistance in the past. The majority felt that technical assistance had helped the agency, although four respondents stated that either it was of no help or the results were mixed.

The areas in which technical assistance were received in the past, as indicated in the survey and during the focus groups, included: team building, conflict resolution, telecommunications, strategic planning, fundraising, fiscal management, multiculturalism, time management, managing a small HIV/AIDS agency, computer training, supervision, program development/design, service delivery, counseling, outreach, data analysis, program evaluation, board training, proposal preparation, stress reduction, suicide prevention, burn-out reduction and women's programming.

Survey respondents then were asked to prioritize specific types of technical assistance according to their importance. In order of priority, participants indicated they need: (1) consultation with "experts"; (2) skills-building/training; and (3) increased information or information access. Focus group feedback yielded similar results.

Participants expressed specific needs for workshops/information/assistance with program evaluation, program design/development, management techniques, program planning, consultation techniques, administration, infra-structure enhancement, fundraising, collaboration with other agencies, cultural sensitivity, and program improvements.

Other areas of assistance that were requested included volunteer recruitment; management and retention; formation of networks; and development of systems and structures. In addition, the service providers in the focus groups desired more effective supervision, planning experts and a collaborative system with different agencies.

Survey participants also were asked to rate their need for training in particular areas from 1 [least needed] to 5 [most needed]. The results identify these training areas as having the greatest need: team building; closing the gap between management, administration and line staff; record keeping; designing new interventions; and documentation. In addition, individual participants requested training in basic concepts of public health—"human sexuality 101"—and basic concepts of the transmission of micro-organisms;

and in any new methods for obtaining rigorous, valid evaluation results given staff and budget limitations.

Finally, survey participants were asked to indicate which methods for administration of technical assistance would be most effective for their agency. All respondents requested group training with staff members of other agencies on specific topics, group training for individual agency and individual consultation to their agency. This demonstrates a desire for personal service along with acknowledgment of the power of collaboration with other organizations.

Consistent with these themes were the findings of the Institute of Health Policy Studies, University of California, San Francisco.

> HIV E&P contractors' most frequent requests for technical assistance and information from the Office of AIDS related to planning and program development: (1) Hands-on, on-site practical support from people who know how to design and implement HIV education and prevention programs; (2) feedback on the information that they report each quarter and annually to the Office of AIDS, particularly about what HIV E&P contractors are doing throughout the state; (3) information about what works and what does not work in HIV education and prevention; and (4) epidemiological information.[5]

Focus Groups

Two definitions of technical assistance came up in focus groups:

> *Pooling resources, agency expertise as well as quality assurance, computer training, anything that we need that we can't do.*

> *Technical assistance is expertise training. It is time off to learn. It can be real finite, like getting a certain packet of materials. It is also getting time to sit down and have conversations like these.*

Focus groups participants expressed technical assistance needs in a number of specific areas.

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5 HIV Prevention in California: Final Report HIV Education and Prevention Evaluation. Prepared for the Office of AIDS, California Department of Health Services by the Institute for Health Policy Studies, University of California, San Francisco. April 1993. p. 79.

Participants asked for the following types of training: training in data analysis and skills-building; training for outreach staff on how to manage paperwork and administrative affairs; training for directors, supervisors and managers on communication with line staff and on communication of information around funding; training in reporting grant information; training for staff in behavior changes and intervention techniques; and leadership training.

To develop and maintain their programs, participants asked for technical assistance for: program design, matching program design with skills of personnel; setting up protocols, policies and procedures; developing culturally appropriate evaluation tools; form development; quality assurance; community organizing skills; and separating outreach work from case management and making a smooth transition from one to the other for clients.

Participants also identified needs for expertise in the following specific areas: access to centralized or computerized information on referral services; acquisition of real estate; architectural assistance; access to legal consultation or legal staff; resources such as comfortable counseling rooms for clients; computers and computer training; developing collaborations; assistance in agency reorganization and restructuring; construction of a corporate financial structure; fundraising; program promotion; development of performance standards for different employee classifications; and support for caregivers.

Focus group participants unanimously agreed that neutral and impartial parties should provide technical assistance. Outside agencies with a combination of support from people who are already in the market were the preferred technical assistance providers.

CONCLUSION

The survey and focus groups examined the areas of program planning, implementation and evaluation. Participants ranked program planning technical assistance as most important with technical assistance program implementation and program evaluation tying for second place.

Clearly, all of these areas are important to the design and realization of appropriate HIV prevention programs. All participants consistently emphasized the need for effective long-term evaluation mechanisms, culturally sensitive policies and procedures, competent staffing, collaboration among agencies, computer database networks, and general support for the difficult but very essential work these agencies perform.

Chapter 8:

Technical Assistance

Exhibit A:

Survey Questions
for
HIV Prevention Plan
Technical Assistance
Needs Assessment

EXHIBIT A

SURVEY QUESTIONS FOR HIV PREVENTION PLAN TECHNICAL ASSISTANCE NEEDS ASSESSMENT

General

1. How would you define technical assistance?

2. Have you or your agency used technical assistance before? If so, in what areas and what kind? Did the assistance have a positive impact on your work?

3. If technical assistance were defined as "helping agencies do their work more effectively with the resources they already have" and did not include increased staff or funding, please rank the following areas in order of importance:

   _____skills-building/training
   _____consultation with "experts"
   _____increased information or information access
   _____other (please specify):_____
   _____

4. What type of prevention services is your agency currently providing?

   a) Outreach
   b) One-on-one education or counseling
   c) Group education or counseling
   d) Community organizing
   e) Media/Events
   f) other:_____

5. To whom do you provide these services? Please identify target populations.

Technical assistance for the HIV Prevention Plan will be concentrated in three program areas: planning, implementation, and evaluation. The following questions are grouped in those areas.

Planning

6. How did your agency's HIV prevention programs get started?

    a) In response to perceived or stated client need without specific funding availability.
    b) In response to funding availability.
    c) In response to client need with specific funding availability.

7. Did you engage in a formal planning process to develop your HIV prevention program?

    a) yes
    b) no

8. Which of the following did you utilize in planning your program? (Circle all that apply.)

    a) epidemiology of behavior among your clientele.
    b) epidemiology of HIV among your clientele.
    c) analysis of methods of reaching your clientele.
    d) training programs for your staff.
    e) HIV prevention materials for use in your service.

9. Please list the things (other than money) that would have helped you to plan your program? Now rank them in order of importance with one being the most important.

Implementation

10. On a scale of 1 to 5 (with 1 being the least well implemented and 5 being the most well implemented), how well do you feel your agency implements its HIV prevention programs?

    1 2 3 4 5

11. What obstacles do you face in successful implementation? (Circle all that apply.)

    a) inability to reach those in greatest need.
    b) retaining trained staff.
    c) information on methods of behavior change.
    d) maintaining uniformity in the quality of service.
    e) level of community knowledge/information about HIV/AIDS.
    f) other:_____
    _____
    _____

12. How helpful would your agency find outside assistance in the following areas? (Please rank each on a scale of 1 [least helpful] to 5 [most helpful].)

Techniques for outreach	1	2	3	4	5
Program promotion	1	2	3	4	5
Client recruitment	1	2	3	4	5
One-on-one counseling techniques	1	2	3	4	5
Skill-building in group process	1	2	3	4	5
Training the trainer	1	2	3	4	5
Behavior change techniques	1	2	3	4	5
Quality assurance	1	2	3	4	5
Community organizing	1	2	3	4	5
Cultural diversity	1	2	3	4	5
Grantwriting	1	2	3	4	5
Community coalition networking	1	2	3	4	5
Access to research information on HIV prevention	1	2	3	4	5
What works/what doesn't in HIV prevention strategies	1	2	3	4	5

Evaluation

13. How are you currently evaluating your prevention services? (Circle all that apply.)

    a) We enumerate the units of service provided.
    b) We measure how well we have met our process and/or outcome objectives.
    c) We measure client satisfaction with the services.
    d) We measure client retention in our programs.
    e) We evaluate the changes in our client's HIV risk behaviors.
    f) We test client knowledge before and after participating in our program.
    g) Other: _____
    _____

14. How do you determine what aspect of your program to evaluate?

    a) We collect only the information mandated by our funders.
    b) We decide what to evaluate based on the individual program.
    c) Both a and b.

15. How do you use the information? (Circle all that apply.)

    a) To complete our funder's reporting requirements.
    b) To prepare funding applications.
    c) To monitor and fine tune the content and implementation of our services.
    d) To develop new services.
    e) To make overall program budgeting decisions.
    f) To make staffing decisions.
    g) Other:_____
    _____

16. What additional information would you like about the impact of the services you provide?

17. What are the obstacles to getting that information? (Circle all that apply.)

    a) Lack of time.
    b) Lack of expertise in evaluation.
    c) It would change the nature of our services for the worse.
    d) Lack of capacity to analyze the information gathered.
    e) Don't know where to get the information.
    f) Other:_____

18. What would help you surmount those obstacles? (Circle all that apply.)

    a) Change in funder reporting requirements.
    b) Training on measuring behavioral outcomes.
    c) Data analysis capability.
    d) Understanding of how epidemiological information relates to our program.
    e) Other:_____

Other questions

19. If trainings were offered, how would you rate the need of your agency in the following areas? (Please rate on a scale of 1 (least needed) to 5 (most needed).

Time management	1	2	3	4	5
Computer skills	1	2	3	4	5
Record keeping	1	2	3	4	5
Documentation	1	2	3	4	5
Form development	1	2	3	4	5
Preparing DPH budget forms	1	2	3	4	5
Preparing DPH budget revision requests	1	2	3	4	5
Bridging the gap between planning, implementation, and evaluation	1	2	3	4	5
Closing the gap between management, administration, and line staff	1	2	3	4	5
Designing new interventions	1	2	3	4	5
Team building	1	2	3	4	5

Other suggestions for trainings_____

20. Technical assistance can be provided in a number of ways. Please rank the following methods in the order of what you feel would be most effective (1) to least effective (5).

    a) _____Group Training with staff members of other agencies on specific topics.
    b) _____Group Training for your individual agency.
    c) _____Individual consultation to your agency.
    d) _____A combination of a) and c).
    e) _____A combination of b) and c).
    f) _____Other:_____

21. This survey has focused on program planning, implementation, evaluation. In which area do you feel the greatest need of technical assistance (please rank 1, 2, and 3).
    _____Program Planning
    _____Program Implementation
    _____Program Evaluation

22. For the area you ranked the highest in Question 20, what is your greatest need for technical assistance?

23. Please list any other areas in which you feel technical assistance would be helpful.

Chapter 8:

Technical Assistance

Exhibit B:

Focus Group Questions
for
HIV Prevention Plan
Technical Assistance
Needs Assessment

EXHIBIT B

FOCUS GROUP QUESTIONS FOR HIV PREVENTION PLAN TECHNICAL ASSISTANCE NEEDS ASSESSMENT

(These basic focus group questions were tailored to the specialized viewpoints of management and line staff. Therefore, the questions were somewhat different depending on whether the focus group is management or line staff.)

General

1. How would you define technical assistance? What does the term mean to you?

2. Has your agency used technical assistance before? What kinds of assistance were provided? Did the assistance have a positive impact on your agency's work?

3. Based on above responses, what are some general technical assistance needs that you feel your agency has?

(In this group, we are going to focus on technical assistance for three program areas: planning, implementation, and evaluation.)

Planning

4. How did your prevention program get started? What kind of planning process did you use?

5. Are there things you would do differently if you were to start the process all over again?

6. Let's list some things (other than money) that would have helped you plan the program. Think skills, expertise, information. If you could get only five of these things, which are the ones you would want in order of most critical to least critical?

Implementation

7. What are some of the successes you've had in implementing your prevention program?

8. Besides insufficient money and staff, what are some of the obstacles you've faced? How did you overcome them?

9. What kind of outside help (other than a larger budget or more staff) have assisted you in implementing the program and overcoming the obstacles?

Now let's rank order these skills, expertise and information.

Evaluation

10. How are you currently evaluating your prevention programs? How do you determine what program aspects to evaluate? How do you use the evaluation information?

11. What are the barriers to getting the information you need? What information would you like to have that you don't have?

12. Besides increased funding, what would help you to surmount the obstacles and get the information you need? From this list, what are the five most important things that would assist you?

13. In which of the following areas do you need assistance in your evaluation process? documentation? form development? creating a database? analyzing the data? report writing and formatting? other?

Format

14. What would be the most effective method for meeting the technical assistance needs we've outlined? Training? with other agencies? at your agency? Individual consultation with agency staff? What staff: management, line staff, a combination?

15. How do you learn best? For example, in lectures, small groups, observing others, interaction, idea/information exchange with other agency staff?

16. Besides money, what kind of technical assistance would enhance your ability to do your job?

17. Who do you feel should provide the technical assistance you need? the AIDS Office? a training/consulting organization (like the Support Center)? peer staff from other HIV Prevention organizations? other?

(Thank you/wrap-up/end)

Chapter 9:

Evaluation

CHAPTER 9: EVALUATION

INTRODUCTION

The HIV Prevention Planning Council (HPPC), the AIDS Office, and the Support Center for Nonprofit Management (as principal sub-contractor) have each acknowledged that evaluation is both useful and necessary. Evaluation is a quality assurance method for determining the effectiveness of a process or program, and serves as a monitoring tool to measure success, to inform decision making, and to direct necessary changes in a process or program. Evaluating the planning process and the specific goals and objectives identified in the plan, will provide important feedback for the HPPC, the AIDS Office and prevention providers.

The San Francisco Department of Public Health (SFDPH) AIDS Office will conduct three levels of evaluation in three distinct phases. Phase I will consist of an evaluation of the process of community planning as outlined in the Supplemental Guidance. Phase II will be an evaluation of the contractual services of the subcontractor (the Support Center), and Phase III will consist of an evaluation of the implementation of the recommendations and priorities described throughout the plan. Progress on Phase I is discussed in detail herein. Phases II and III will take place throughout 1995.

Phase II will be conducted by the SFDPH AIDS Office and will be guided by standard DPH monitoring protocols, modified as necessary to capture the unique nature of the planning process, as well as through structured interviews with HPPC members. Phase III will be conducted jointly by the AIDS Office and planning council members in regular bi-monthly meetings of the council.

Evaluation is both a useful and necessary tool for improving and fine-tuning the HIV prevention planning process and the specific goals and objectives which have been recommended as a result of that planning. Evaluation is an ongoing process that provides feedback for the HPPC, the AIDS Office and prevention providers to ensure that the planning process and the goals and objectives have been carried out identified in the plan.

There are three basic components to the evaluation of Phase I. These are: 1) defining the goals of the evaluation; 2) completing a logic model of the planning process; and 3) creating an evaluation plan by defining program objectives methodology for measuring accomplishment.

Goals of the Evaluation

The goals of the Phase I evaluation are focused on both the *process* by which the community HIV prevention planning process took place and the *outcome(s)* of that effort. Briefly, the intent is to assess *how* the process occurred and *what* the results were.

The Logic Model

The logic model is a graphic representation of the community planning process which shows the logical connections among the conditions that caused the AIDS Office to embark on the community planning process, the activities aimed at addressing those conditions, and the outcomes that have resulted from those activities. The components of the logic model are:

- Conditions - what the community planning process is designed to change (or the basic conditions of concern);
- Activities - what components of the community planning process will be undertaken to solve the problems/conditions;
- Outcomes (short-term program goals) - immediate changes anticipated as a result of the community planning process.

The Evaluation Plan

The evaluation plan identifies the goals and objectives for the community planning process and criteria for evaluating whether or not they have been achieved in timely fashion.

EVALUATION OF THE COMMUNITY PLANNING PROCESS

Goals of the Evaluation

Goal #1: **To document that the community planning process has actually taken place according to guidelines established by the CDC.**

Activities:

Maintain records on the nomination, selection, and demographics of members of the HIV Prevention Planning Council (HPPC) - San Francisco's new HIV Prevention Planning body.

Evaluation:

In this instance, at least three questions have to be asked and answered. These are:

- *Was the nomination of members for the HIV Prevention Planning Council an open process?*
- *Does the composition of the HIV Prevention Planning Council reflect the characteristics of the current and projected epidemic in San Francisco?*
- *Have records been maintained on all aspects of the nomination and selection process and the demographic composition of members of the HPPC.*

Status Report:
Question 1:

Nominations and Appointment to the new HIV Prevention Planning Council (or HPPC) were solicited through an open call for nominations from the prevention provider and general communities. It was explained that this was a new body which was being created to address the development of an HIV Prevention Plan for San Francisco. The specific objective was to receive nominations, by mid-January 1994, of individuals who reflect the population characteristics of the current and projected HIV/AIDS epidemic in San Francisco. A community meeting

was held in late December 1993 during which the nominations process was outlined and participation was encouraged.

By the cutoff date, 93 nominations had been received. These nominations, with supporting background information, were submitted to an ad-hoc committee composed of the Chief of the AIDS Office Prevention Services Branch (also the AIDS Office designated co-chair of the HPPC) and the chairs of the AIDS Prevention Advisory Committee, the Ryan White Care Council, and the People of Advisory Committee.

The ad-hoc screening committee reviewed all of the nominations to determine which ones best fit the criteria of diversity, representativeness and other population characteristics. The committee selected 37 nominees whose names were then forwarded to the Director of the AIDS Office and the Director of the Department of Public Health for consideration and approval.

On February 1, 1994, following their formal appointment, letters were sent to all 37 individuals notifying them of their appointment and of the first meeting of the HPPC on February 10, 1994.

Question 2:
The membership of the HPPC closely reflects the characteristics of the HIV epidemic (both current and projected) in San Francisco. The membership is ethnically diverse with representatives from the African-American (8 members), Latino (8 members), Asian/Pacific Islander (5 members), Native American (2 members) and Anglo (14 members) communities. It also represents diversity in sexual orientation and gender identity with 10 gay/bisexual men; 2 lesbians; 11 heterosexual men; 10 heterosexual women; and 1 bisexual transgendered/ transsexual woman. Since San Francisco is currently experiencing an increase in HIV infection among young people, the HPPC also has 6 members (both male and female) under the age of 26.

Question 3:
Records have been maintained of all formal and informal nominations for membership on the HPPC as well as the steps

undertaken in the process of selecting the members. Those records include information regarding the demographics of the candidates as well as the multiple "hats" each wears in community contacts.

As membership on the HPPC has changed over the planning period, the demographics of the council have also changed. Records have been maintained which detail the demographic profile of HPPC members at outset, after three months, and after eight months.

Goal #2: To determine whether or not the short-term program goals of community planning are being met.

Activities:

The short-term goals of the community planning process were spelled out in the by-laws of the HPPC as:

- to develop and prepare San Francisco's comprehensive HIV Prevention Plan.
- to assess existing community resources to determine the community's capability to respond to the HIV epidemic.
- to establish priority HIV prevention needs by target populations and propose high priority strategies and interventions.
- to identify the technical assistance and capacity development needs of community-based HIV prevention providers in the areas of program planning, intervention and evaluation for effective participation in the planning process.
- to consider how Counseling/Testing/Referral/Partner Notification (CTRPN); early intervention, primary care, and other HIV-related services: Sexually Transmitted Disease, Tuberculosis, and substance abuse prevention and treatment; mental health services; and other public health needs are addressed within the Comprehensive HIV Prevention Plan for San Francisco.
- to evaluate the HIV Prevention Community Planning process and the responsiveness and effectiveness of administrative mechanisms for addressing HIV prevention priorities and allocating funds for their implementation.

Evaluation:

Evaluation of these short-term goals is based on whether or not each goal was considered in the community planning process and whether or not they were built into the HIV Prevention Plan. Documentation is found in the minutes of the HPPC meetings and in the draft plan document.

Status Report:

The first of the short-term goals (development of a comprehensive HIV Prevention Plan for San Francisco) has been achieved as illustrated by this document. It is understood that this plan will be further revised and refined over the next several months (a final plan will be submitted to CDC by December 31, 1994) and updated as needed in the future.

In the AIDS Office application for continued CDC Cooperative Agreement funding for 1995, a number of questions were posed and answered in the section dealing with the Community Planning Process. The answers to these questions in part address the evaluation of the short-term goals and include:

- *Was the prioritization of needs based on epidemiologic profile, resource inventory, gap analysis, and research on target populations?*

  In prioritizing needs, all of these factors were taken into consideration by both the Criteria for Priority Setting Subcommittee and the HPPC when it made its decisions on priority needs.

- *Was the prioritization of interventions based on a list of unmet needs, effectiveness, cost effectiveness, theory, and community norms and values?*

  In establishing priority strategies and interventions, the HPPC responded to recommendations from the Strategies and Interventions Subcommittee which carefully considered all of these factors as well as issues about whether or not it was feasible to continue/initiate interventions for which their was neither a theoretical

base or evaluative data to assess effectiveness or cost-effectiveness.

- *Were the technical assistance and capacity development needs of community-based HIV prevention providers identified?*

Chapter 8 (Technical Assistance) in this document details the findings of the assessment of technical assistance and capacity development needs of both providers and the grantee. A plan to address these needs will be developed in 1995 as part of the implementation of this plan for prevention.

- *Were the Counseling/Testing/Referral/Partner Notification (CTRPN); early intervention, primary care, and other HIV-related services: Sexually Transmitted Disease, Tuberculosis, and substance abuse prevention and treatment; mental health services; and other public health needs addressed within the Comprehensive HIV Prevention Plan for San Francisco?*

In Chapter 6 (Goals and Objectives) specific actions are identified for addressing linkages with other, related, health services.

Goal #3: **To identify the strengths and weaknesses of the community planning process.**

Activities:

AIDS Office staff, co-chairs of the HPPC and Support Center consultants will meet to explore and document the strengths and weaknesses of the community planning process as implemented in San Francisco.

Evaluation:

Evaluation of this goal will be based on the completeness of the identification process and the report developed from it.

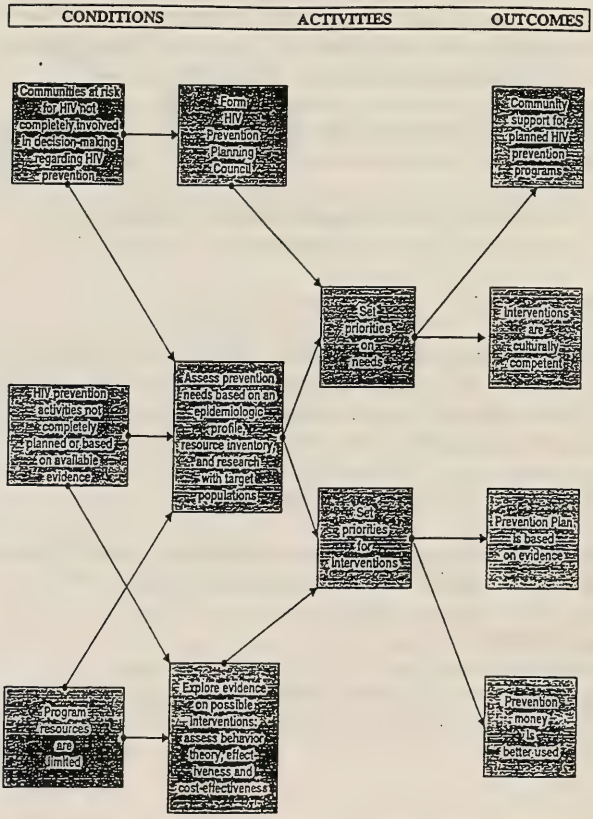
Status Report:

This evaluation will take place subsequent to the final meeting of the HIV Prevention Planning Council in 1994.

THE LOGIC MODEL

The Logic Model used in the San Francisco Community Planning Process closely follows the model identified by the Academy for Educational Development in its Handbook for HIV Prevention Community Planning. Within the framework of that model, a number of process objectives and measures have been identified and utilized in its implementation. These include: ensuring that there is an open process for the nomination and selection of HPPC members and that the membership represents the characteristics of the current and projected epidemic in San Francisco; that prevention needs are prioritized on the basis of available evidence; and that proposed interventions are based on evidence documenting unmet needs, effectiveness/cost-effectiveness, theory, and community norms and values.

THE SAN FRANCISCO COMMUNITY PLANNING PROCESS
LOGIC MODEL


CONDITIONS
ACTIVITIES
OUTCOMES
Communities at risk for HIV not completely involved in decision-making regarding HIV prevention
Form HIV Prevention Planning Council
Community support for planned HIV prevention programs
Set priorities on needs
Interventions are culturally competent
HIV prevention activities not completely planned or based on available evidence
Assess prevention needs based on an epidemiologic profile, resource inventory, and research with target populations
Set priorities for interventions
Prevention Plan is based on evidence
Program resources are limited
Explore evidence on possible interventions, assess behavior theory, effectiveness and cost-effectiveness
Prevention money is better used

From the Logic Model, it is important to now look at the Core Objectives (defined by CDC and adopted by the AIDS Office and the HPPC) and the measures utilized to determine whether or not they have been accomplished. Following is a listing of those Core Objectives and the specific measures employed by the AIDS Office to assess achievement:

- **Ensure that the nomination for community planning group membership is an open process.**

  Measure(s): A written policy detailing what the nomination and selection process is. This policy was included in the AIDS Office application for CDC Cooperative Agreement funding for HIV Prevention Community Planning in February, 1994. (Implementation status of this policy is reported above.)

- **Ensure that the community planning group reflects in its composition, the characteristics of the current and projected epidemic in its jurisdiction.**

  Measure(s): A roster of the membership of the HPPC and the group(s) they represent within the community is the major assessment tool. The Membership Roster and a Demographic Profile of the HPPC members is included in this chapter.

- **Base prioritization of needs on epidemiologic profile, resource inventory, gap analysis, and research on target populations.**

  Measure(s): Evidence exists that a procedure for prioritizing needs has been developed and that unmet needs have been reviewed and prioritized. Chapter 4 (Priority Setting Criteria) and Chapter 5 (Comprehensive Summary and Needs Assessment) document achievement of this objective.

- **Base prioritization of interventions on list of unmet needs, effectiveness, cost-effectiveness, theory, and community norms and values.**

  Measure(s): Evidence exists in Chapter 4 (Priority Setting Criteria) that a procedure for prioritizing interventions has been developed and that interventions have been reviewed and prioritized. Chapter 3 (Strategies and Interventions) presents a comprehensive report of HPPC efforts to define current and future interventions from multiple perspectives. It has been noted that the findings stop short of stating

that a particular intervention has proven effective to prevent HIV infections in a given population. They do, however, offer some general conclusions about the effectiveness of particular interventions and whether or not they should continue to be utilized.

- **Develop the HIV prevention funding application based on the community plan.**

  Measure(s): Letters of concurrence/non-concurrence from the community planning group. In this instance, the application for funding under the 1995 CDC Cooperative Agreement was written with the priorities, unmet needs, and proposed interventions in mind. Although full implementation of the HIV Prevention Plan recommendations will not occur until calendar year 1996 (due to funding/contract cycles), Requests for Proposal will be issued in 1995 soliciting proposals intended to implement the provisions of the HIV Prevention Plan.

THE EVALUATION PLAN

The Evaluation Plan is based on determining if the goals of the evaluation have been met and whether or not the conditions, activities, and outcomes in the Logic Model have been achieved. In this instance, the Evaluation Plan concentrates on the outcomes detailed in the Logic Model:

- Ensuring community support for planned HIV prevention programs;
- Ensuring that the recommended interventions in the HIV Prevention Plan are culturally competent;
- Ensuring that the HIV Prevention Plan is based on documented evidence;
- Ensuring that HIV Prevention funds are used for prevention interventions recommended in the HIV Prevention Plan.

CONCLUSIONS AND NEXT STEPS

The preliminary Phase I evaluation clearly documents the existence of a participatory, evidence-based community planning process. Nominations for the planning group were made through an open process. The HIV Prevention Planning Council reflected in its composition, the characteristics of the current and projected HIV epidemic in San Francisco. The HPPC developed an epidemiological profile of HIV in San Francisco, developed a resource inventory, conducted research on each of the priority populations identified in the planning process, analyzed gaps between HIV prevention

needs and available resources to determine unmet needs, established goals and objectives for meeting those unmet needs, and preliminarily identified priority strategies and interventions for implementing those objectives. The goals and objectives were based on assessments of unmet needs, effectiveness, cost-effectiveness, theory and community norms and values. Finally, the CDC Cooperative Agreement funding application for 1995 is based on the draft HIV Prevention Plan (which will be finalized by December 1994).

As was found to be the case in the statewide community planning process, several important issues were identified in Phase I of the evaluation. These will be explored in greater depth as the evaluation proceeds into Phase II. They include:

- the logistical challenges of community planning in a city as diverse as San Francisco.

- the "different ways of knowing" that have emerged as the HPPC has deliberated over *scientific (quantitative) evidence* and *information (qualitative)*, and the impact these differences have on policy decision making and a broader understanding of the HIV epidemic.

- the differences and tensions created between advocacy for a constituency and citywide/population wide policy perspectives, particularly when individual participants are called upon to shift their focus away from lobbying for their own constituency to the "greater good."

- the short and long term benefits of participation in the community planning process for individuals, organizations, constituents, and public institutions.

- the impact of the extremely short time frame on the quality of decision-making, particularly regarding the most difficult decisions.

- the influence of the key players, particularly the AIDS Office staff, the co-chairs, and the Support Center in shaping, nurturing, and stimulating the community planning process.